



HIV Preventive Education
Information Kit for School Teachers



United Nations
Educational, Scientific and
Cultural Organization

UNESCO Bangkok
HIV Coordination, Adolescent Reproductive
and School Health Unit (HARSH)

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A poster in an exhibition held on World AIDS Day 2005
in Ujjain district of Madhya Pradesh state, India.

The poster conveys the message of how HIV is transmitted
without being explicit in sexual terms. The Hindi caption reads
“Patience is Protection,” referring to abstinence as a means
of HIV prevention.

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Preface

Dear Educator:

Given the current absence of a cure or vaccine for HIV and AIDS, preventive education and the transfer of relevant skills/attitudes are critical to reducing young people's vulnerability and are an effective response to the pandemic. As an educator, you play a key role in ensuring that young people gain the knowledge, skills and attitudes needed to adopt healthy practices and live healthy lives. You can also help to create understanding and reduce fear, stigma and discrimination towards those living with or affected by HIV and AIDS.

The *HIV Preventive Education Information Kit for School Teachers* contains up-to-date, relevant, school-focused information about HIV prevention and AIDS. We believe it provides you with essential techniques to mobilize action and respond to HIV and AIDS within your school and community, at large.

In 2002, UNESCO Bangkok developed an advocacy toolkit on HIV, AIDS and education targeted at middle- and senior-level officials of the Ministries of Education in the Asia-Pacific region. The 2002 advocacy toolkit focused on promoting HIV preventive education and increasing awareness of the virus' impact on the Education sector. Feedback from the field studies of that toolkit indicated that there was a need to create a similar toolkit geared towards school teachers.

UNESCO Bangkok, thus, developed this information kit to encourage and assist you and your colleagues in increasing awareness about HIV and AIDS' impact and the importance of HIV preventive education. Your close interaction with young people means that you have a direct influence on their minds and behaviour. You are, indeed, one of the key forces in preventing HIV infection among young people. You can make a difference by adopting school-based responses to HIV and AIDS.

Please join in efforts to strengthen the Education sector's response to HIV and AIDS at the school level. Your valuable support and action is needed. I sincerely believe that this kit can make a difference in our continued efforts to provide high quality HIV preventive education to all young people in the Asia-Pacific region.



Sheldon Shaeffer
Director, UNESCO Bangkok

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Introduction and User Guide

The *HIV Preventive Education Information Kit for School Teachers* is an attempt to provide teachers and teacher trainees with the basic information that they should know when teaching young people about HIV and AIDS. With HIV expanding across Asia, there is an urgent need to equip teachers with the knowledge and skills to play an effective role in HIV preventive education.

This collection of fact sheets covers a range of issues that are important for teachers to understand when teaching children at both primary and secondary levels. They aim to raise awareness among teachers of HIV and AIDS-related issues and suggest ways in which the subject may be addressed at the school level. They can also be used as freestanding resources for open learning or as adjuncts for in-service teacher training. In all cases, it is important that they be tailored to meet the needs of particular national education sector responses to HIV and AIDS.

The Kit begins with basic bio-medical information about HIV and AIDS to allow readers to understand how infection can be averted. Understanding these facts about HIV can be useful in combating related myths and stigmatisation of children living with or affected by HIV and AIDS.

Indeed, the impact of HIV and AIDS on children is beginning to be experienced on a larger scale as parents fall ill and die. The second part of the Kit provides the bigger picture of how HIV is spreading in the Asia-Pacific region. It is important that national HIV and AIDS strategies address this.

The next part of the Kit gives particular attention to describing the impact of HIV on families, communities and schools. A separate sheet addresses issues related to orphans and vulnerable children.

The multiple roles of schools in fighting HIV and AIDS are outlined with a focus on preventive education and a life skills-based approach. The importance of linking schools and preventive education to HIV and AIDS-related services is described.

Issues relating to vulnerability and risky behaviour are covered in the theme sheets on women and girls, men who have sex with men, and injecting drug use.

Suggestions are made for further reading and a glossary of key terms is provided.

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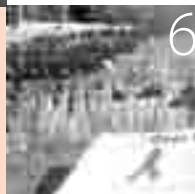
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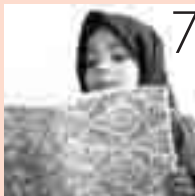
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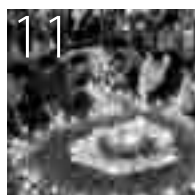
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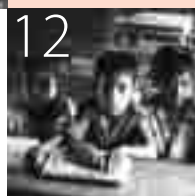
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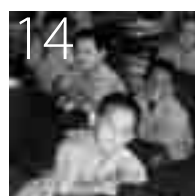
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Basic Facts About **HIV and AIDS**



UNESCO/S. Baker

Basic Facts About HIV and AIDS

It is important for every teacher to know the basic facts about HIV and AIDS. This section will help in addressing some of the myths and misconceptions that are widespread and which undermine prevention efforts.

What is HIV?

HIV is a virus. The letters H-I-V stand for Human Immunodeficiency Virus. That means it is a virus that attacks and destroys the immune system in human beings. The immune system is the body's natural defence system to fight off infections and disease.

The HIV virus originated in Africa in the twentieth century, and has been able to spread across the world through the global mobility of people. Today, almost no country has been unaffected by the human loss and financial costs of treating and preventing the spread of the HIV virus.

The HIV virus belongs to a special class of viruses. Once it has entered the body, it lives in the white blood cells, using them as food to grow and reproduce. In the process of reproducing itself, it kills these cells. In particular, it destroys a type of cell that normally protects us from disease. This cell is called a CD4 cell. A healthy person has between 450 to 1,200 of these cells in each cubic millimetre of blood.

The HIV virus is generally slow to impact on the health of an infected individual. Some people become sick quickly, but most adults do not develop symptoms for around 10 years. As HIV progressively weakens the immune system, the person infected becomes vulnerable to a range of illnesses, including pneumonia and tuberculosis. These are called 'opportunistic infections'.

If a person is living with HIV, they are said to be HIV positive. Because of the slow progression of disease, a person who is living with HIV may appear perfectly healthy and normal. This fact has helped the virus spread across the world. Fortunately, the virus cannot survive long outside the human body. It can only be transmitted in a limited number of ways. Even so, the virus has been remarkably successful. At the end of 2007, there were 33.2 million people estimated by UNAIDS to be living with the virus. There were 2.1 million AIDS-related deaths in 2007.¹ To date, more than 25 million people have already died from HIV and AIDS.²

When a person begins developing opportunistic infections because HIV has weakened their immune system, that person is considered to have 'AIDS'.

1. UNAIDS/WHO. (2007) *2007 AIDS Epidemic Update*. Geneva: UNAIDS.

2. UNAIDS. (2006) *2006 Report on the Global AIDS Epidemic: A UNAIDS 10th Anniversary Special Edition*. Geneva: UNAIDS.



What is AIDS?

AIDS is a condition where a person living with HIV has become seriously ill because their immune system can no longer defend them effectively against disease. The letters A-I-D-S stand for Acquired Immunodeficiency Syndrome. A person with AIDS may die of diseases that would not kill a person with a healthy immune system.

A person with AIDS typically has lost a large number of CD4 cells. The CD4 cell count is 200 cells per cubic millimetre of blood or less, and this is insufficient to provide the body with protection.

As AIDS is signalled by the presence of opportunistic diseases such as pneumonia, it is necessary to be tested for HIV in order to confirm their cause. Early confirmation of HIV's presence can lead to sooner use of life-prolonging medical care. Access to HIV testing is important for treating the virus.

Can HIV and AIDS be cured?

At the present time, there is not yet a cure for HIV and AIDS. Once in a human body, it is currently impossible to remove the virus. Doctors and scientists are experimenting in hopes of developing a vaccine – a drug that will prevent people from becoming infected with HIV. No one is sure how long it will take to develop such a vaccine, or if the scientists will be successful. An effective vaccine is right now a long way off.

Today, there are treatments for HIV which delay the onset of AIDS. Some drugs are designed to treat opportunistic infections. Drugs called “antiretrovirals” can reduce the level of HIV in a person's body to almost undetectable levels. They prevent HIV from reproducing itself and destroying the body's immune system. However, anti-HIV drugs are highly toxic, unpleasant to take and can cause serious side effects. Yet, if patients take their medication on schedule, it enables them to live for many more years, perhaps even decades, than if they were not under treatment. As these treatments are relatively new, no one is sure how long they will extend a person's life, or if they will lose effectiveness and stop working at some point in the future.

Unfortunately, antiretroviral therapy (ART) can be expensive and not enough of it is available in many countries, especially developing countries. The absence of a vaccine or cure, and the limited availability of antiretrovirals, means prevention is the best response to HIV and AIDS.

If someone is HIV positive, the earlier they begin treatment, the more chance there is that treatment will be effective. It is, therefore, important that people who may have been exposed to the virus take an HIV test to know whether or not they have HIV.

How can HIV or AIDS be identified?

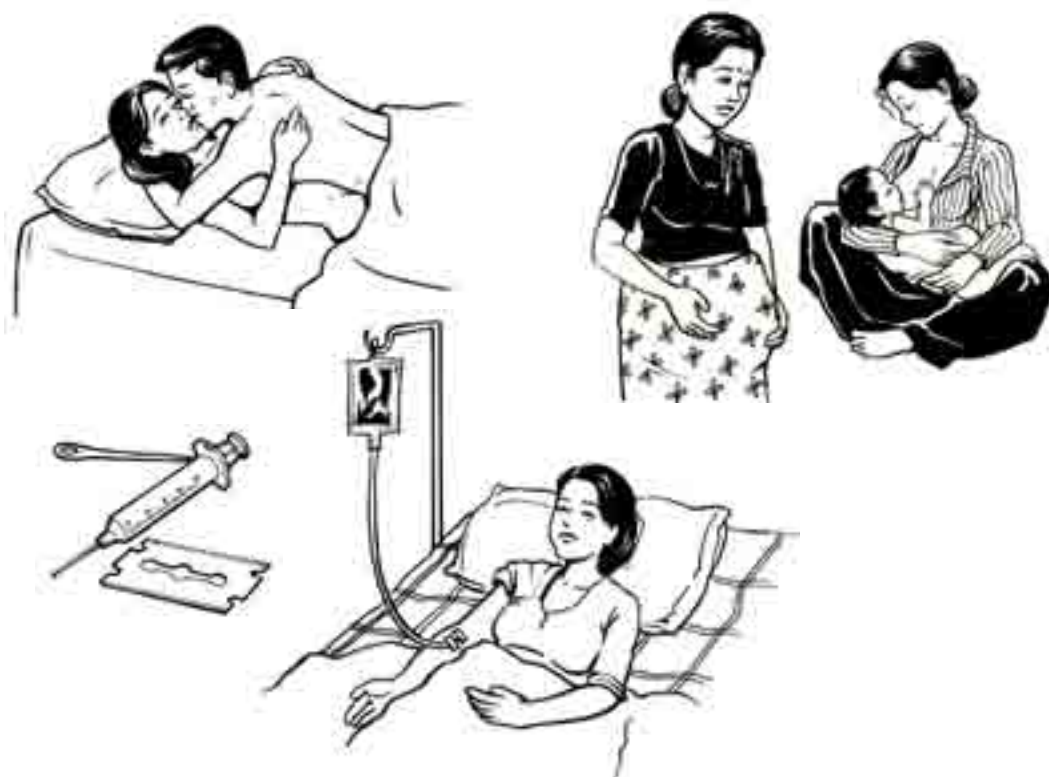
The only way to know for certain is to take a blood test to see if the HIV virus is present. The test should be given after counselling and after obtaining informed consent, and with confidentiality. If the test has a positive result, a second test should be done to confirm it because sometimes there are false positive results. If a person tests positive, they should immediately seek counselling (if it is not already being provided) and medical help to understand their condition and the best ways to cope with it. Generally, a person should wait three months after they suspect they have been exposed to HIV to be tested. This is because the virus cannot be detected in the very early period of infection. Different tests have different sensitivities, but all should be able to detect the presence of the virus in a person's blood *after* three months. This three-month period of undetectable infection is often called the ‘window period’. If a person has been infected, they can transmit HIV even before testing is capable of revealing the presence of the virus. Thus, they can pass on the virus to others without knowing that they are themselves infected.



How is HIV transmitted?

HIV cannot travel by itself or survive long outside the human body. It needs human body fluids to live, reproduce and infect other people. It is transmitted through the blood, semen, vaginal secretions or breast milk of an infected person. There are three main methods through which it is spread:

1. **Unprotected Sex** – Sexual intercourse (vaginal, anal or oral) with an infected person is the most common way HIV is transmitted. Women are biologically at greater risk of HIV infection than men during vaginal sex. They are culturally vulnerable, too, because their gender status often undermines their ability to insist on safe sex using a condom. Unprotected anal sex, whether male to male or male to female, is a high risk, especially to the receptive partner. This is because the lining of the anus and rectum is easily damaged during intercourse. Oral sex poses a risk when semen is ejaculated into the mouth, or when either partner has cuts or sores in the mouth caused by sexually transmitted infections (STIs), recent tooth brushing or canker sores. These cuts can allow the virus to enter the bloodstream.
2. **Exchanges of Blood** – This happens when people share unsterilized needles or syringes, usually to inject drugs, with a person living with HIV. It may also happen in some sub-standard health care settings, or through transfusions of blood that have not been screened for the virus. The use of unsterilized equipment in tattooing can also spread the virus.
3. **Parent-to-Child** – If a woman is living with HIV, she will have a 20% to 45% chance of passing on the virus to her child during pregnancy, birth or breastfeeding. With treatment using certain drugs, that can drop to a 2% or lower chance.³ It is important to keep in mind that women are rarely solely responsible for the transmission of HIV to their children. There is always a chain of events across people and across circumstances. There are many possible scenarios for how a



Illustrations: Krishna Gopal Shrestha

3. Ki-Moon, B. (2007) *Children and the Millenium Development Goals*. New York: UNICEF.



woman contracts HIV and then passes it to her infant. A woman may have received infected blood during a transfusion or from an unclean injection. Or a woman may be living with HIV because she had unprotected sex with someone infected with HIV either willingly or by force. Or the father of the child may have contracted the infection during a previous sexual relationship and passed the virus to her without knowing, or he may have had unprotected sex with other partners more recently without telling her.

How can a person reduce the risk of becoming infected with HIV?

As there is no cure, it is vital that people know how to prevent HIV transmission.

1. **Sexual Contact.** Three strategies are generally promoted to reduce the risk of HIV infection through sexual contact. The more sexual partners a person has, the greater the risk of infection, especially if sexual intercourse is unprotected by a condom. These are:

- ▶ Abstinence from sexual intercourse
- ▶ Sexual fidelity to one partner, or reducing the number of sex partners
- ▶ Safer sex through using a condom (male or female condom)

These three are sometimes called the 'ABC method'. (A-Abstain, B-Be faithful, and C-Use a condom if you can't abstain or be faithful). Successful prevention efforts require all three to reduce sexual networking and increase safer sex. An approach that promotes only abstinence will not be fully effective because not all sexually active men and women are willing or able to abstain from sex. Of course, sexual fidelity can only prove effective if both partners observe it. All three strategies should be regarded as an integral approach to HIV prevention.

Ensuring that STIs are diagnosed and treated is important, too. Studies show that having an STI can increase the risk of both acquiring and transmitting the HIV virus. This is true for STIs that produce sores or breaks in the skin (such as syphilis, herpes and chancroid) as well as for those that do not (such as chlamydia and gonorrhea).

Finally, coercive sex presents a high risk of HIV transmission because vaginal linings and the lining of the anus can be damaged in the process. Coercive sex can take place in marriage as well as outside of it.

2. **Unsterile Needles and Syringes.** These must be avoided at all costs, as they are a means of HIV transmission. Previously used needles and syringes should be disinfected with bleach to reduce the risk. Tattooing equipment should be sterile. Drug users should never share used syringes with anyone else. Blood transfusions should be avoided in cases where the blood supply has not been screened for the virus.



Illustrations: Krishna Gopal Shrestha

3. **Parent-to-Child Transmission.** Infection from a mother living with HIV to her child can be prevented by drugs that stop HIV transmission to the foetus. Where possible, mothers living with HIV should not breastfeed because doing so may also transmit HIV. It is important for women who are pregnant or considering becoming pregnant and who may have been exposed to the HIV virus to seek an HIV test and counselling.



Illustrations: Krishna Gopal Shrestha

Are young people vulnerable to HIV infection?

Yes. Young people are vulnerable to STIs and HIV because they start to be sexually active and may take risks. Young people may experiment with drugs and alcohol, which raises the likelihood that they will engage in unsafe sexual behaviours. It is important that they recognise their vulnerability and risk-taking. It is likewise essential that they have the information and skills necessary to protect themselves, as well as their current and future sexual partners.

Myths about HIV and AIDS

Many myths surround HIV and AIDS. The following are NOT true:

- ▶ Only foreigners have HIV and AIDS.
- ▶ Only bad people get HIV and AIDS.
- ▶ If someone gets HIV, they did something to deserve it.
- ▶ People living with HIV and AIDS want to infect other people.
- ▶ You can get HIV when an infected person coughs or sneezes.
- ▶ You can get HIV by sharing food or utensils with an infected person.
- ▶ You can get HIV by touching, hugging or kissing an infected person, or by coming in contact with their sweat or tears.
- ▶ You can get HIV by sharing clothes.
- ▶ You can get HIV by sitting next to another student or by sharing pens, textbooks, etc.
- ▶ Shaking hands can spread HIV.
- ▶ You can get HIV by sharing toilets and bathrooms with an infected person.
- ▶ Mosquitoes and other insects can infect you with HIV.



HIV and AIDS in the Asia-Pacific Region



UNESCO/S. Baker

HIV and AIDS in the Asia-Pacific Region

It is useful to be able to place the HIV epidemic into a regional context. HIV does not respect borders.

The Asia-Pacific region at risk

The Asia-Pacific region has the second largest number of people living with HIV and AIDS in the world. Africa has the most. At the end of 2007, an estimated 4.9 million people in the Asia-Pacific region were living with HIV and AIDS. Approximately 440,000 of them were newly infected during 2007 alone.¹ No country in Asia or the Pacific is free of HIV and AIDS.

Many doctors and scientists say it is important to take action now. Without expanded prevention efforts, HIV prevalence may grow to almost 10 million people living with HIV in Asia and the Pacific by 2020.²

Prevention of a worse epidemic

The Asia-Pacific region has been described as a low prevalence region. This means the percentage of people living with HIV and AIDS is less than 1% of the adult population in most countries.³ Concerted action needs to be taken to prevent the virus spreading into the population, at large, and further increasing its chances of transmission. Countries in the world that are experiencing high prevalence epidemics are encountering significant negative impacts on their development progress, including on their education systems. Asia can still avoid the major socio-economic impacts of HIV and AIDS that have occurred in many African countries.

Low prevalence – high numbers

The Asia-Pacific region is home to more people than any other part of the world. Even if a small percentage of people in some countries are infected, it often translates into a substantial number of people living with HIV and AIDS.

1. UNAIDS/WHO. (2007) *2007 AIDS Epidemic Update*. Geneva: UNAIDS.

2. Commission on AIDS in Asia. (2008) *Redefining AIDS in Asia Crafting an Effective Response*. New Delhi: Oxford University Press.

3. UNAIDS/WHO. (2007) *2007 AIDS Epidemic Update*. Geneva: UNAIDS.



As an example, let's compare two countries. The adult HIV prevalence rate in India is estimated to be about 0.36% of the population. The rate in South Africa is much higher at about 18.8%.⁴ Nonetheless, because India's population is so much larger than South Africa's, it actually has more people living with the virus.

Low prevalence – high risk

Although most countries in Asia and the Pacific have a relatively small percentage of people infected, there are geographical areas within countries where prevalence is high.

Myanmar provides an example. The national adult infection rate was 1.3% in 2005.⁵ But in some areas, it is higher. In these areas, communities may be facing significant impacts from HIV and AIDS, including the orphaning of children. It is important to target HIV prevention, care, treatment and support programmes at these HIV 'hot spots' to control the epidemic and its consequences, as well as to reduce the risk of transmission spreading to other less infected localities. Schools in these areas will require increased levels of support to ensure that children who are living with or affected by HIV and AIDS are able to continue their education.

Furthermore, infection rates are very high among groups who engage in behaviours that put them at risk of acquiring HIV, such as injecting drugs users, female sex workers, their male clients/partners and men who have sex with men. It is estimated that 75% of all HIV infections in Asia can be linked directly to these three behaviours.⁶

Economic costs

2

Thailand, Myanmar, Cambodia and Papua New Guinea have the highest HIV prevalence rates in the Asia-Pacific region. The impact on development has been significant. According to UNAIDS, the Asia-Pacific region is losing \$29 billion a year because of the HIV and AIDS epidemic. By comparison, the economic impact of the 2004 tsunami was about \$8 billion.⁷

Success stories

Thailand and Cambodia are two nations which have proven that prevention programmes can work if countries are committed to them and develop appropriate strategies to implement them. These programmes involve the distribution and promotion of condom use in brothels and education campaigns for the public. Both have slowed the rate at which the epidemic is spreading. Although approximately 1.2 million people in Thailand are living with HIV or AIDS, that's about 25% less than if it had not implemented its programme.⁸ A similar programme in Cambodia was estimated to have reduced national prevalence from 2% in 1998 to 0.9% in 2006.⁹

4. Ibid.

5. UNAIDS. (2006) *2006 Report on the Global AIDS Epidemic: A UNAIDS 10th Anniversary Special Edition*. Geneva: UNAIDS.

6. Commission on AIDS in Asia. (2008) *Redefining AIDS in Asia Crafting an Effective Response*. New Delhi: Oxford University Press.

7. UNICEF. (2006) *Report on the East Asia and Pacific Regional Consultation on Children and HIV and AIDS*. Bangkok: UNICEF for Asia and Pacific Regional Office.

8. Horn, R. (2006) "Back to No Future" in *Time* (Asia Edition). Oct 16, 2000, Vol. 156, No. 15.

9. UNAIDS/WHO. (2007) *2007 AIDS Epidemic Update*. Geneva: UNAIDS.



The Asia-Pacific Region by the Numbers¹⁰

- ▶ 4.9 million people were living with HIV in Asia and the Pacific in 2007.
- ▶ Approximately 300,000 people died from AIDS-related illnesses in 2007.
- ▶ There are about half a million children who have been orphaned because of AIDS.
- ▶ Fifty percent of new infections are among young people (15-25 years).
- ▶ There are close to 1,400 new infections of people under 24 years in Asia every day.
- ▶ The majority of new infections are clients of sex workers.
- ▶ More than 11,000 children under the age of 15 were newly infected in 2005.
- ▶ There were 8,500 children under the age of 15 in immediate need of antiretroviral treatment in 2005.
- ▶ There were 7,500 mothers in need of prevention of parent-to-child transmission (PPTCT) in 2005.
- ▶ There were 440,000 people newly infected with HIV in 2007.

Stopping the spread

A successful response to HIV and AIDS requires a blend of prevention, treatment, care and support programmes. Turning the tide on the epidemic will require a core minimum package consisting of:

- ▶ Promotion of condoms, lubricants and treatment of sexually transmitted infections (STIs) for male and female sex workers and their clients, as well as the general population
- ▶ Information, education and communication campaigns
- ▶ Clean needles and substitution drug treatment for injecting drug users
- ▶ Delay of sexual intercourse, monogamy and condom use for young people
- ▶ Voluntary confidential counselling and testing
- ▶ Prevention of parent-to-child transmission
- ▶ Access to antiretroviral drugs (ARVs) and other treatments
- ▶ Prevention of HIV transmission among men who have sex with men

10. See sources 5, 7, 9 of this section.



This package will only be successful if it reaches 80% of the key populations vulnerable to HIV, including providing 80% of those who need antiretroviral therapy with those drugs. This is the 'critical threshold' needed to reverse the spread of the epidemic. The cost would be approximately 4% of most countries' health care budgets.

The Education Sector Response to HIV and AIDS

The Education sector response to HIV and AIDS is a critically important component of any national multi-sectoral HIV plan and programme. The key elements of the Education response are:

- ▶ An Education sector policy on HIV and AIDS that addresses both HIV prevention and issues arising from the impact of AIDS on the school;
- ▶ HIV and AIDS training for Ministry of Education staff at all levels;
- ▶ HIV preventive education curriculum development and the preparation of age-specific teaching and learning materials;
- ▶ Pre-service and in-service teacher training to implement the HIV preventive education curriculum;
- ▶ Co-curricular activities such as peer education; and
- ▶ Monitoring arrangements to ensure programme effectiveness.

4



The Impact of HIV on Families, Communities and Schools

Jodhpur, India © 2000 Ketan K. Joshi, Courtesy of Photoshare



Cover photo: Adolescent girls give a street theater performance as part of a parade on World AIDS Day in Jodhpur, India. The banner on the truck says "AIDS: Protect yourself and your family." This event was organized by the Association François Xavier Bagnoud (AFXB).

The Impact of HIV on Families, Communities and Schools

While HIV prevention must be the first priority for any national response to HIV and AIDS, the complex impact of the epidemic on society must also be understood and addressed. Children are often disproportionately affected by the consequences of HIV infection in the community, especially if their parents carry the virus. They certainly require additional protection, care and support. (See *Theme Sheet 10 on Orphans and Vulnerable Children*.)

Stigma and discrimination

One of the worst consequences of HIV and AIDS is the stigma and discrimination faced by those living with the virus or perceived to be. Stigma and discrimination not only harm those living with HIV and AIDS, they help fuel the epidemic. Because people fear the reactions of others if they are known to have HIV, they do not get tested and learn their HIV status. They may be infected and unknowingly passing it on to others.

HIV and AIDS-related discrimination can result in people living with HIV who are aware of their status, hiding their secret and becoming withdrawn and isolated. It can lower their self-esteem and affect their health. Self-stigmatisation or the feeling of shame that they experience has led people who have tested positive to become depressed and contemplate or commit suicide. In extreme cases, some individuals have even been killed by their community.



Illustrations: Krishna Gopal Shrestha



People tend to fear the unknown. Stigma also results from irrational fears of contracting HIV. Education about HIV and AIDS can help reduce this, and teachers have a significant role to play.

Much of the stigma surrounding HIV and AIDS comes from the fact that the virus is often transmitted by people engaged in behaviours the community often frowns upon, such as injecting drug use, sex work or men having sex with men.

Women living with HIV may also suffer stigma because some people believe they must have engaged in sex with multiple partners to have become infected. However, many women who have been infected were monogamous and faithful to their husbands or the male partners who infected them. It was, in fact, the risky behaviour of the husband or male partner which caused their infections.

Research on HIV and AIDS-related discrimination in Asia carried out by the Asia Pacific Network of People Living with HIV/AIDS (APN+) found that the major area of discrimination was in the health-care sector, where treatment could be refused, confidentiality was breached and delays in provision of health services occurred. Within the family and the community, it was found that women living with HIV were significantly more likely to suffer discrimination than men. They were often subject to ridicule, harassment, physical assault and some were forced to change their residence.

The education sector is another area for HIV and AIDS-related discrimination. Children living with HIV may be refused admission at school. Children affected by HIV and AIDS may be bullied and ridiculed by other children. Teachers living with HIV may have to leave the school.

Successful Approaches to Stigma and Discrimination¹

- ▶ Continuing advocacy for social change in response to HIV and AIDS-related stigma and discrimination involving people living with HIV and AIDS and religious/political leaders
- ▶ Empowerment and involvement of people living with or affected by HIV and AIDS
- ▶ Action to tackle gender, sexual and racial inequalities and stereotypes, which feed stigma and discrimination
- ▶ Lifeskills education and counselling to help children living with or affected by HIV and AIDS cope with stigma
- ▶ Legal protection for people living with HIV and AIDS
- ▶ Workplace policies based on the ILO "Code of Practice on HIV/AIDS and the World of Work"²
- ▶ Enforcement of codes of ethics and professional conduct in health settings

1. Aggleton, P. (2002) *A Conceptual Framework and A Basis for Action. HIV/AIDS Stigma and Discrimination. Best Practice Collection*. Geneva: UNAIDS.

2. ILO. (2001) *An ILO Code of Practice on HIV/AIDS and the World of Work*. Geneva: ILO.



HIV hits hardest at the grassroots level

The most devastating impact of HIV and AIDS is at the grassroots level – on individuals, families, schools and communities. HIV and AIDS push families deeper into poverty, and create growing numbers of orphans, homeless and street children. AIDS causes students, teachers and education staff to fall ill and die. It strains community resources to provide care and support for those living with or affected by HIV and AIDS.

The stigma caused by HIV and AIDS also often elicits two responses at the grassroots level: people turn against one another because of fear resulting from myths and misconceptions, or they rally around each other and strengthen bonds of care and support. Both reactions can sometimes be seen within the same community.

Impact on families

Families can be torn apart or pulled together in the face of HIV and AIDS. Children experience emotional distress at watching their parent or parents die. They lose their most valuable source of love, protection and care. Many of these children will either be absorbed by their extended families (such as grandparents), sent to state or religious institutions, or end up on the street. None of these options may be equipped to provide children with the individualized attention they need as they are growing up. Grandparents and other relatives have to shoulder the financial responsibilities of raising children orphaned by AIDS, which may push them into poverty. They must also deal with the difficult psycho-social problems these children may be experiencing because of the loss of their parents. However, children almost always prefer to stay with their extended family and within their community. Institutionalising them in orphanages should be considered as a last resort.

Children who are living with HIV suffer on many levels. Without access to treatment, HIV progresses more rapidly in young children than adults.³ Aside from physical illnesses that come with the onset of AIDS, children living with HIV are often targets of stigma and discrimination. Feelings of rejection, along with physical illness, can often lead to depression and behavioural problems if care, treatment and support are not available.

HIV and AIDS often have a devastating impact on household incomes. Parents living with AIDS may be too sick to make a living, and any remaining income is consumed by health care and related costs, such as funerals. As a result, children (especially girls) from families affected by HIV and AIDS are often forced to leave school to help with household duties or earn money. Studies in Cambodia have shown as many as 2 in 5 children affected by HIV and AIDS leave school and start working.⁴ Many children also end up having to go without basic necessities, such as food, leading to malnutrition. Malnourished children have many health problems, and their weakened physical condition makes learning difficult.

Tragically, some families may also reject their own members living with HIV. At a Buddhist temple in Lopburi, Thailand, there is a room containing the cremated remains of thousands of people who have died from AIDS. The small boxes of dust and bones have never been collected by relatives to be kept, buried or scattered to the winds in a final religious or spiritual ceremony. The stigma of AIDS is so strong that even in death, victims of the disease are often rejected.

3. UNICEF. (2006) *Report on the East Asia and Pacific Regional Consultation on Children and HIV and AIDS*. Bangkok: UNICEF for East Asia and Pacific Regional Office.

4. NAM. (n.d.) "Children and HIV News," *AIDS map* webpage. Accessed at: <http://www.aidsmap.com/en/docs/F00CECBA-8C0F-11D5-8D07-00508B9ACEB1.asp>



Impact on communities

HIV and AIDS can divide or unite communities. A common reaction to HIV and AIDS is the discrimination against and stigmatization of people living with HIV. Attempts to “cast out” those affected by the disease – from villages, hospitals, schools and houses of worship – have been experienced in virtually all parts of the world and among all ethnic groups, as well as in all social and economic classes. Sadly, some spiritual leaders have refused care and religious burials to the HIV-infected.

On the other hand, some religious and spiritual groups have taken a strong proactive role in dispelling fear, ignorance, stigma and discrimination. Churches, temples and mosques have taken in and offered care, education and support to adults living with HIV and children orphaned by AIDS or living with HIV.

In some communities in sub-Saharan Africa, AIDS has taken the lives of so many young and middle-aged adults that the social structures of these communities have been affected. With many young, productive adults no longer present, more burdens have been placed on the elderly and the very young. Children may be forced to leave school and begin working to support their families, and the elderly may need to return to work, if possible, for the same reasons. These burdens can cause financial and emotional stress within families and the communities. While this is not a common situation in Asian communities at the present time, it could become so if responses to the epidemic are not scaled up. Some Pacific Island communities may be especially vulnerable to this scenario because they are small, and so the numbers of adults dying will have a greater impact.

Small communities also depend upon agriculture and small businesses. As people die of AIDS-related illnesses, farms and businesses lose valued employees and people with specialized skills. Some farms and businesses shut completely. This is why HIV and AIDS have been called a developmental issue. In places such as sub-Saharan Africa, so many people have been infected in some areas that the labour force has been decreasing. A shortage of workers will naturally have a negative impact on economic growth and development. In this way, HIV and AIDS can impede a country's development and wipe out hard-won economic and developmental gains. While this situation is not yet prevalent in most of the Asia-Pacific region, it could become so unless prevention programmes become more effective.

Impact on schools

HIV and AIDS affect the demand for and supply of education, as well as its quality.⁵ The impact can be significant in high HIV prevalence communities. Children affected by HIV and AIDS often drop out of school. Unless they have access to treatment, children living with HIV will eventually die. If a parent or sibling can no longer work, the child may be required to find work to make up the difference to support the family. If the child is a girl, she may be also required to take care of the home. Children must sometimes assume the role of caring for a parent or sibling who is ill with AIDS. Even if the children don't have to work, the loss of income suffered by a sick parent may mean that the family can no longer afford to pay for school fees, and so their children drop out. More often than not, girls leave or are taken out of school in greater numbers than boys.

5. Shaeffer, S. (1994) *The Impact of HIV/AIDS on Education: A Review of Literature and Experience*. Bangkok: UNESCO.



HIV and AIDS also impacts on the education system as a whole. As children and young people become ill, leave school and perhaps die, there are fewer students. That decreases demand for schooling. With HIV and AIDS infecting members of communities, teachers are bound to be among those infected. As teachers become ill and possibly die, their numbers diminish and their valuable experience is lost. Shortages of teachers can negatively affect the quality of education, as classrooms become overcrowded and school systems may be forced to recruit less experienced teachers or even unqualified teachers.

Teachers living with HIV need treatment, care and support. They need antiretroviral therapy, and they need to be encouraged and supported to continue teaching and serving the community. Their knowledge, experience and contributions are invaluable and must not be needlessly lost.

The parents of other children or school officials may block children living with or affected by HIV and AIDS from coming to school because of the irrational fear of infection. Or the children, themselves, may decide they can no longer endure the teasing and bullying they suffer.

Children from families with an ill parent may be malnourished because the family faces poverty. Weakened physically, they may not be able to perform well academically. They may also have psycho-social problems because of their situation at home or due to the stigma they experience in the school or community. Teachers need to be trained to recognize the causes of these behaviours and how to deal with them.



Illustrations: Krishna Gopal Shrestha



What Teachers Can Do

- ▶ Involve community leaders. Leaders have a strong influence on communities and can reduce stigma and discrimination by setting an example. They can also encourage the local government unit to put HIV and AIDS on its agenda.
- ▶ Be knowledgeable about how HIV and AIDS impact on children and reach out to the community.
- ▶ Be sensitive to the individual psycho-social needs of all of your students, including those who are living with or affected by HIV and AIDS.
- ▶ Actively support the teaching of HIV preventive education in your school.
- ▶ Be a positive role model in raising awareness to reduce stigma and discrimination in the school and community. Practice what you preach.
- ▶ Create a supportive environment in your class to address gender inequalities.
- ▶ Ensure that the classroom is a place of safety, free from bullying, violence and harassment.
- ▶ Involve people living with HIV and AIDS in the school's response. Invite organizations of people living with HIV and AIDS to help organize a response in your school.
- ▶ Support the implementation of the workplace policy on HIV and AIDS in your school setting.
- ▶ Encourage teachers' unions to take an active role in advocacy and in addressing the impact of AIDS on teachers.



The Role of Schools in Responding to HIV and AIDS



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The Role of Schools in Responding to HIV and AIDS

The Education sector is a critical partner in the national multi-sectoral response to HIV and AIDS. It is through education that young people can be provided with the knowledge and skills to enable them to protect themselves and their peers from HIV infection. Schools and teachers have important roles to play in developing citizens of tomorrow who will be free from HIV infection.

Schools shape attitudes and behaviours

Schools play an important role in shaping the attitudes, views and behaviours of young people. HIV and AIDS are present in almost every country. Because young people lack knowledge and tend to experiment with new behaviours that may be risky, they are more likely to be affected by the epidemic than any other age groups. Schools can help shape their responses to this reality. Peer groups at school can be motivated to provide support and positive attitudes towards people living with HIV and AIDS. Schools can provide an environment in which young people can be educated about HIV and AIDS.

Studies from around the world show that young people who stay in school are less likely to get HIV and AIDS than those who drop out.¹ Schooling increases earning power, self-confidence and social status, allowing young people to take greater control over their choices relating to personal relationships.

Cornerstones of community response

Schools are pillars of their communities. They are trusted by students and parents alike. As a place where friendships are formed and bonds are established between teachers, pupils and parents, schools are more than just places where education takes place. They are often the centre of community activity, especially in small villages or rural areas. This gives them the potential – provided they have the leadership, the resources and the staff training – to be the cornerstone of a community response to the HIV and AIDS epidemic. They can act as a vehicle for community discussion and for the mobilisation of activities, and help break down stigma and discrimination. They can assist in monitoring the impact of the epidemic. Because schools reach very large numbers of young people with information that can save their lives, their role in HIV prevention can be powerful.

1. The Global Coalition on Women and AIDS. (2005) *Educate Girls, Fight AIDS*, Issue 1. Geneva: UNAIDS.



A sanctuary for affected students

Schools can be a sanctuary of stability and normalcy for young people living with or affected by HIV and AIDS. Students may be living with HIV, or their home lives may be troubled or in disarray because a relative is infected or ill. While at school, they are with friends and teachers. The atmosphere and routines are known and predictable. Such an environment provides an important degree of stability and comfort. For a school to be a sanctuary, however, it must address the problems of stigma and discrimination, which cannot be tolerated in a school setting.

Educators are in an important position to provide psycho-social support for children who are living with or affected by HIV and AIDS, or vulnerable to HIV. Teachers are often the first to notice when a student is having psycho-social problems. Teachers, counsellors and other school officials need to be trained to recognize, provide support and deal with these situations. Simply put, schools are part of the social safety net.

What schools can do

Incorporate HIV preventive education into the school curricula

Making HIV preventive education a compulsory part of the school curriculum is an effective way of providing students with the information to protect themselves. HIV and AIDS education should be part of broader health education, which encompasses reproductive health, substance abuse and sexually-transmitted infections.

Schools should be teaching life skills-based education as an approach across the curriculum. Aside from being useful in the prevention of HIV, it teaches young people the skills they need to resist peer pressure and make good choices regarding a range of health and behavioural issues, such as drug, alcohol and tobacco use.

To accomplish this, teachers need to be trained on how to teach HIV and AIDS education through a life skills-based approach. It will be necessary to develop teaching and learning materials that are both relevant and culturally appropriate to the community.

School principals, teachers and communities may also need to be convinced of the need to allow these subjects to be taught. Many have concerns that teaching about human sexuality, reproductive health and HIV prevention will encourage young people to become sexually active. According to UNAIDS, studies from 113 countries show this is not true. In fact, young people are more likely to delay the start of sexual activity if they have received education in these subjects.²

Ensure those living with or affected by HIV and AIDS stay in school

Students and teachers living with or affected by HIV and AIDS face personal challenges that may force them to leave school or their jobs. These include illness, family responsibilities and poverty. Yet they have the same rights to education and employment as everyone else.

It is imperative to work with community-based organizations (CBOs), NGOs, provincial authorities and community groups to keep teachers and students at school. This can be through material assistance, provision of psycho-social support and activities to combat stigma and discrimination. Schools can also make special provisions for affected students and teachers to enable those with

2. Ibid, p.1.



illnesses or extra familial responsibilities to make up for lost time. This requires flexible teaching and learning schedules.

Provide for those who are living with HIV

People living with or affected by HIV and AIDS have particular medical and psycho-social needs. There are several ways in which schools can help meet those needs.

Special support is required for children living with HIV. Teachers and peers can play a role in counselling and supporting affected students. Specific teacher training and training in peer education may be necessary. Schools can develop referral systems to health and welfare services and inform teachers about these services.

Reduce stigma and discrimination

HIV and AIDS-related stigma derives from the virus' association with illegal or taboo behaviours, and with the irrational fear many people have of infection.

Because schools reach children and young people in their formative years, they are well placed to counter misconceptions about HIV and AIDS, and also to promote the rights of people living with HIV. This will help reduce negative attitudes towards people living with HIV.

Schools can organize discussions – not just among students, but also members of the community – about HIV and AIDS. They can invite people who are living with HIV and AIDS, or organizations of people living with HIV and AIDS, to speak about their experiences. This takes HIV from the abstract to the real. It gives the epidemic a human face, and can help dispel fears and increase both understanding and compassion.

3

Out-of-School Young People

The young people most vulnerable to HIV are often those who are out of school. Young people can be out of school for a variety of reasons. They may be too poor to pay school fees, or even lack money for transportation to school. They may have to work to support their families. They may be street children, without a family. Some are legally barred from school because they are members of minority communities and don't possess identity or citizenship papers. They may be the children of sex workers or other groups who are stigmatized by the community. Out-of-school young people often don't have access to knowledge, information and services that will help protect them from HIV.

Schools can play a role in reaching these young people with opportunities for non-formal education, HIV preventive education and other services. The Dakopha Group in Thailand and the "School-based Healthy Living and HIV and AIDS Prevention Education" (SHAPE) programme in Myanmar are two examples of this approach.

The Dakopha Group is attached to Bakham Phittayaknom School in the Nakorn Ratchasima province of Thailand. The group was started after the Asian economic crisis of 1997 to build relationships between in- and out-of-school young people because, with the economy in bad



shape, those in school one day were likely to find themselves out of school the next day. The group of young people underwent a series of capacity-building trainings – in leadership, life skills, participatory community research and community theatre. In the end, they formed their own community-based organization, the Dakopha Group. The group conducts preventive education activities both in and out of school in the form of assemblies, camps, and community performances, as well as by using general outreach strategies. The schools' relationship with the community has helped to mobilize support for Dakopha and HIV preventive education within the community.³

Approximately 26% of young people in Myanmar leave school after primary school and do not proceed to secondary education.⁴ Most HIV preventive education initiatives for young people start at the secondary level, from age 15 and above. Thus, children who drop out before this level are left without adequate knowledge or skills for HIV prevention. Following the successful national implementation of the formal SHAPE project for primary school students, which started in 1998, the approach was adapted for application in a non-formal setting to reach out-of school children and young people in 2002. The strong emphasis on HIV and AIDS, STIs and drug abuse prevention in the school-based lifeskills initiative was adapted for out-of-school young people with the objective to prevent the spread of HIV among young people, and at the same time provide extended learning opportunities.

In most cases these out-of-school young people need to work to help support their families or to help their families at home or in the family business. The schools that have been participating in SHAPE use their networks for social mobilization – parent-teacher associations, community leaders, parents, and religious leaders – to mobilize support for the out-of-school young people to participate in non-formal education. The project has also helped a number of young people return to school.⁵

3. Interview with Greg Carl, former UNICEF EAPRO Education Officer in charge of Lifeskills Education. Bangkok 2006.
4. UIS-UNESCO. (2006) "UIS Statistics in Brief – Myanmar," UNESCO Institute for Statistics webpage. Accessed at: http://stats.uis.unesco.org/unesco/TableViewer/document.aspx?ReportId=121&IF_Language=eng&BR_Country=1040&BR_Region=40515
5. Ibid.

Preventive Education



Ahmedabad, India © 2006 Rajal Thaker, Courtesy of Photoshare

Cover photo: Dr. Rajal Thaker answers questions on HIV/AIDS at the School Adolescent Education Programme (SAEP) for the school children of Dascroi Taluka near Ahmedabad, India. The programme was organized by the International Centre for Entrepreneurship and Career Development (ICECD) in Ahmedabad.

Preventive Education

Providing young people with good quality HIV preventive education should be a priority for education reform processes everywhere. At present, countries are at different stages in developing school-based programmes. Some are just starting to develop the curriculum and train teachers, others are further ahead and reaching widespread coverage. All have to find ways to address socially sensitive topics relating to sexuality and sexual health at school. This represents one of the more difficult challenges to be faced by governmental education ministries in developing preventive education and by teachers in implementing it in class.

Facing the facts about young people

It is a fact of life that a certain number of young people everywhere engage in sexual activity. Whether or not adults approve, warn them of the dangers or threaten punishment, some young people will have sex anyway. It is a misconception that young people who have sex are rebellious, disruptive and academically disinclined; likewise, just because some young people are good students does not mean that they abstain from having sex.

Adolescence is a time of discovery and experimentation. Adolescents tend to think they are immortal and invincible, and that bad things only happen to others. They take risks - some more than others. It is not only boys or young people over the age of 16 who are having sexual experiences. Some adolescents below the age of 15 are also having sex.¹ Some are also experimenting with drugs and alcohol. A significant minority of adolescents may be involved in same-sex behaviours.

Teachers (and parents) need to recognize this reality if they are going to make a difference in the lives of their students. They must provide their students with the right information to help them make good choices about their behaviour.

Parents may resist the teaching of HIV preventive education in school even if teachers think it's a good idea. They may need to be persuaded to support preventive education. However, in many contexts, parents would prefer teachers to educate their children about HIV and AIDS than to do it themselves.

Informing to save lives

More than 20 years after HIV and AIDS first appeared in the Asia-Pacific region, some young people have still never heard of it. Many others have misconceptions or believe the myths about HIV. In many countries, young women are less knowledgeable about HIV than young men. These young women and men are vulnerable or at risk of being infected. For young people to be able to protect themselves, they need honest and accurate information.

1. Wellings, K., Collumbien, M., Slaymaker, E., Singh, S., Hodges, Z., Patel, D., and Bajos, N. (2006) "Sexual Behaviour in Context: A Global Perspective," in *Lancet*, 11/11/2006, Vol. 368 Issue 9548, pp.1706-1728.



Teaching sex education through a life skills-based approach is the first important step in protecting young people. Sexuality and relationship education must address HIV prevention, reproductive health and gender stereotypes. Young people have a right to know and understand these issues because they are directly affected by them.

Young people also have the right to know their HIV status. They need to know where they can get voluntary and confidential counselling and testing, as well as other reproductive health and support services.

Guidelines for preventive education

Many parents express concern that teaching sex education will promote or cause an increase in sexual activity among young people. Research from around the world shows this is not true. In fact, studies from 113 countries on five continents found that teaching about HIV, AIDS and sexuality helps reduce early sexual activity and other risk behaviors:²

- ▶ Start early, before children and young people become sexually active.
- ▶ Address all the factors that contribute to HIV vulnerability, including gender inequality, homosexuality, sex work, poverty, discrimination, cultural norms and beliefs, drug use and the position of minority groups.
- ▶ Clearly explain the different levels of risk associated with anal, vaginal and oral sex, respectively.
- ▶ Present the full range of options for HIV prevention, including delaying sexual activity, reducing the number of sexual partners and correct and consistent condom use.
- ▶ Develop skills in teaching topics that are sensitive so as not to lose face in class.
- ▶ Equip school staff with the skills to listen to students and handle sensitive issues in a non-judgemental manner.
- ▶ Use various informal channels, such as the media and community networks, to reinforce the messages of school-based preventive education.
- ▶ Integrate HIV and AIDS education into both curricular and extra-curricular activities, such as sports and school camps.
- ▶ Actively involve teachers and young people in the design and delivery of the curricula.

Life skills-based education for healthy behaviour³

Experience in preventing the spread of HIV has shown that knowledge is necessary, but not sufficient in itself to reduce risky behaviour. Active learning is also required. Life skills-based education is a participatory, interactive approach to learning aimed at producing behaviour change or behaviour development. Research suggests that it needs to be holistically integrated across the school in all subjects. It is designed to address a balance of three areas: knowledge, attitudes, and skills.

2. The Global Coalition on Women and AIDS. (2005) *Educate Girls, Fight AIDS*, Issue 1. Geneva: UNAIDS.

3. This section was adapted from UNICEF EAPRO Senior Staff Training on HIV and AIDS, 18-20 Oct 05, Vientiane, Lao PDR: "The Role of Life Skills Education" by Kenneth Griffin, Associate Professor, Division of Prevention and Health Behaviour, Department of Public Health, Weill Medical College, Cornell University.



The goals of the life skills-based approach are to:

- ▶ Address the social and psychological forces that promote risky behaviour by developing young people's ability to resist social pressures from peers and the media that encourage the behaviour;
- ▶ Promote the ability to be less vulnerable to the internal psychological forces that promote risky behaviour;
- ▶ Increase resilience in the face of stress; and
- ▶ Enhance self-sufficiency in making informed decisions about one's behaviour.

What does this mean for the teacher and HIV preventive education?

- ▶ **Communication skills** can be applied so that young people can influence others to abstain from sex, and support them in that decision. For those who can't or won't abstain, they can influence them to practice safer sex with the use of condoms.
- ▶ **Refusal or negotiation skills** can be taught so young people can learn and practice ways to refuse sexual intercourse or negotiate the use of condoms.
- ▶ **Decision-making skills** can be applied so that young people can consider if, when, and how to express intimacy with someone they care about, what safer behaviours they are comfortable with, and weigh the consequences of each course of action.
- ▶ **Critical thinking skills** can be applied so that young people can identify media messages regarding HIV and AIDS, gender roles, and contraception, and analyze their accuracy and assumptions. If they have further questions, they can effectively seek out reliable sources of information about these topics.

Combined with an open, honest, and caring atmosphere, interactive methods may promote an open classroom and safe spaces for discussions of controversial issues. Ideally, open discussion in a supportive environment should begin to help address the shame, silence, and stigma associated with HIV and AIDS. It could help address the denial, blame, and discrimination that delay positive steps toward prevention.

Interactive teaching methods include:

- ▶ Facilitated group discussion
- ▶ Classroom demonstrations
- ▶ Small group activities
- ▶ Debates
- ▶ Demonstration
- ▶ Behavioural rehearsal or role play

It is important to teach young people how to recognize and resist pressures to engage in unhealthy behaviours (peer refusal skills, analyzing media messages). It is important to provide accurate information regarding rates of behaviour in order to reduce the perception that a particular behaviour is common behaviour.



Teachers may feel threatened and uncomfortable as HIV preventive education providers because of cultural prohibitions regarding drug use and sexuality, or because effective prevention involves interactive and innovative teaching techniques which teachers may never have used before. It is important to provide them with regular in-service training and support to help them master new teaching techniques, overcome discomfort and prejudice, and generate teacher enthusiasm and support. Studies show that teachers who are initially reluctant to teach HIV prevention in a way that encourages student participation can overcome this hurdle during training sessions.

To instruct students about resisting the pressure to begin having sex, teachers can start off with instruction and demonstration. Explain to students that when their boyfriend or girlfriend pressures them to begin having sex, they can respond in a variety of ways, including saying no firmly and confidently or negotiating non-penetrative sex. Demonstrate what could be said or give some examples of appropriate responses.

Then use feedback and social reinforcement. For one or two students in each group, review what they did well and what they could do better. For example, if a student was not convincing in assertively saying no, tell them in constructive and supportive ways that they could have been more assertive or used another negotiation technique.

Use extended practice. Ask students which responses they think would work best in different real-life situations. Ask them to practice one of the techniques in a situation where they are being pressured over the next week. Have students report back to class what happened.

International Commitments on HIV and AIDS



Toronto, Canada © 2006 Emmanuel Dipo Olorin, Courtesy of Photoshare

Cover photo: In Toronto, Ontario, Canada, a banner reminds the world of the reality of AIDS during the XVI International AIDS Conference in August 2006.

International Commitments on HIV and AIDS

A rights-based approach

International commitments are one of the cornerstones of a rights-based approach to HIV and AIDS. They are a public pledge by governments to respond to the HIV and AIDS epidemic with appropriate, fair and substantial measures. They are a recognition by governments that they have obligations to address issues such as discrimination, gender inequality and unequal access to basic services. Most governments in the Asia-Pacific region have signed the major international agreements on HIV and AIDS. These agreements provide an important basis for action.

Countries that have signed international agreements are duty-bound to uphold and fulfil these legally-binding obligations. These agreements, including human rights conventions, mandate government accountability. They endorse the principles of participation and empowerment, particularly for vulnerable and marginalized groups. As such, it is incumbent upon countries to allow and assist marginalized groups and other claimholders to strengthen their capacities in all areas that will lead to their empowerment.

1

Declaration of Commitment on HIV and AIDS

In June 2001, heads of state and government representatives met at the United Nations General Assembly Special Session on HIV and AIDS. The Declaration of Commitment on HIV and AIDS is a clear statement of their commitment in the response to HIV and AIDS. It demands that:

- ▶ Prevention be the mainstay of our response;
- ▶ Respect for the rights of people living with HIV and AIDS must remain paramount in the response to HIV;
- ▶ Empowering women is essential; and
- ▶ Children orphaned by HIV and AIDS need special assistance.

Millennium Development Goals

The Millennium Development Goals (MDGs) were adopted by member countries of the United Nations to create better conditions for the people of the world. The Goals represent a global partnership based on commitments and targets established at world summits during the 1990s. They are intended to respond to the world's main development challenges and to the calls of civil society. The MDGs promote poverty reduction, education, maternal health, and gender equality. They also set targets to combat child mortality, AIDS and other diseases.



Three of the targets set by the MDGs deal directly with education, HIV and AIDS. Those targets are:

- Target 2** ► Ensure that all boys and girls complete primary school.
- Target 3** ► Eliminate gender disparities in primary and secondary education preferably by 2005, and at all levels by 2015.
- Target 6** ► Halt and begin to reverse the spread of HIV and AIDS.

Convention on the Rights of the Child

The Convention on the Rights of the Child, or CRC, was adopted by the UN General Assembly in 1989 with 192 signatory nations.¹ It is a legally-binding instrument derived from legal codes and cultural traditions. According to UNICEF's website,

"...the Convention is a universally agreed set of non-negotiable standards and obligations. These basic standards—also called human rights—set minimum entitlements and freedoms that should be respected by governments. They are founded on respect for the dignity and worth of each individual, regardless of race, colour, gender, language, religion, opinions, origins, wealth, birth status or ability and therefore apply to every human being everywhere. With these rights comes the obligation on both governments and individuals not to infringe on the parallel rights of others. These standards are both interdependent and indivisible; we cannot ensure some rights without—or at the expense of—other rights."²

The Convention guarantees children's rights to education, health, and information. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the Convention stipulates that the best interests of the child shall be a primary consideration. HIV prevention efforts for children and young people are part and parcel of education, health and acting in the best interests of the child.

EDUCAIDS: The Global Initiative on Education, HIV and AIDS

With UNESCO as lead agency, EDUCAIDS is a joint initiative carried out in partnership with ten United Nations agencies. Its purpose is to help governments and other key stakeholders put together a comprehensive response in the area of HIV and AIDS education.

EDUCAIDS provides a response to HIV preventive education that is simple and standardized, yet comprehensive and sensitive to different cultures and societies. The purposes of the initiative are:

- Increasing awareness and commitment to HIV and AIDS issues among opinion leaders and policy makers who influence education.
- Supporting governments and other key stakeholders as they prepare a comprehensive educational response to HIV preventive education and mitigate the impact of HIV and AIDS on the education sector.

1. OHCHR. (1989) "Convention on the Rights of the Child" UNGA Resolution 44/25 and entered in accord with Art. 49 (2 Sept. 1990)
2. UNICEF Web Site. (n/d) "Convention on the Rights of the Child" accessed at www.unicef.org/crc/ [10 Oct. 08]



- ▶ Assisting in the development of comprehensive policies and programmes that reduce vulnerability and risk by combining effective elements of a comprehensive response that includes curricula, teacher training, school health programmes, workplace policies, and school feeding programmes.
- ▶ Reaching out through non-formal education to out-of-school young people, orphans and other vulnerable populations.
- ▶ Working to develop improved tools for planning, management and monitoring at the country level.

The ultimate goal of EDUCAIDS is to make a significant impact on the HIV and AIDS epidemic at the national level.³

Education for All (EFA)

In 1990, delegates from 155 countries, as well as representatives from some 150 organizations, agreed at the World Conference on Education for All to universalize primary education and massively reduce illiteracy before the end of the decade. UNESCO was chosen as the lead agency to spearhead this effort.

UNESCO's mission is to promote education as a fundamental right, to improve the quality of education and to stimulate experimentation, innovation and policy dialogue. As the lead agency in EFA, UNESCO coordinates, mobilizes and harmonizes the efforts of governments, development agencies, civil society and non-governmental organizations.

To implement EFA, UNESCO has helped establish two important bodies – the High-Level Group and the Working Group on Education for All. The first meets annually with the goal of strengthening political commitment and mobilizing resources. It consists of 30 ministers of education, along with representatives of development agencies and civil society. The Working Group provides technical assistance, support and information exchange between partners and stakeholders.

UNESCO has also drafted the Global Action Plan for EFA, and publishes the annual *EFA Global Monitoring Report*. The first outlines roles and strategies for partners and stakeholders. The Monitoring Report measures progress countries make towards meeting EFA goals in the areas of primary education, adult literacy, gender parity and quality. HIV and AIDS-related education is integrated in the EFA framework.

Dakar Framework for Action

This framework was adopted by 164 nations at the World Education Forum, which was held in Dakar, Senegal, in 2000. The framework notes that HIV and AIDS are impeding attempts to achieve Education for All, with Article 64, in particular, urging action on the part of the Education sector:

Education institutions and structures should create a safe and supportive environment for children and young people in a world with HIV and AIDS, and strengthen their protection from sexual abuse and other forms of exploitation. Flexible non-formal approaches should be adopted to reach children and adults affected by HIV and AIDS, with particular attention to AIDS orphans. Curricula based on life skills approaches should include all aspects of HIV and AIDS care and prevention. Parents and communities should benefit from HIV and AIDS related programmes. Teachers must be adequately trained both in-service and pre-service in providing HIV and AIDS education, and teachers affected by the pandemic should be supported at all levels.

3. See www.educaids.org



Theme Sheet: Women and Girls

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Cover photo: Education for All

Theme Sheet: Women and Girls

This sheet explores the vulnerability of women and girls to HIV infection. Globally, half the adults living with HIV are now women. The percent of adults in the Asia-Pacific region living with HIV that are women is not this high, but the figure is growing quickly. It has climbed from below 20% to almost 30% in the last 15 years.¹ Preventing HIV infection among this group is key to reducing overall HIV infection in the region.

The profile of new infections is increasingly among married women or those in a relationship with only one male partner. For example, in 2005, about one third of new HIV infections in Thailand occurred among married women.² In 2006, a large proportion of women with HIV in India appear to have acquired the virus from regular partners who were infected during paid sex.³

Reasons for increased vulnerability

A number of factors make women and girls more vulnerable to HIV than men and boys. These factors are biological, social, cultural and economic.

Biologically, research shows that females are more vulnerable than males to HIV and other STIs during sexual intercourse with an infected partner. Young girls are even more vulnerable because their reproductive tracts are still immature and considerably more sensitive to being torn or damaged.⁴ Beyond biology, the social, cultural and economic factors that make women and girls more vulnerable all have a common cause.

Influence of gender inequality

Gender is a set of characteristics and behaviours that a society expects a man or woman to have, and is socially built, rather than being fixed. Thus, 'gender' is different from 'sex' (e.g. male versus female). Sex is the biological and physical differences between males and females. For example, males and females have different reproductive organs and, therefore, females can become pregnant, but males cannot.

1. UNAIDS/WHO. (Dec. 2007) *2007 AIDS Epidemic Update*. Geneva: UNAIDS.
2. UNAIDS/WHO. (Dec. 2006) *2006 Epidemic Update: UNAIDS/WHO Fact Sheet Asia*. Geneva: UNAIDS.
3. UNAIDS/WHO. (Dec. 2006) *2006 AIDS Epidemic Update*. Geneva: UNAIDS.
4. Stated by Dr. Carol Jenkins during the UNICEF HIV and AIDS Officers and Child Protection Officers Training, 22-26 May 2006, Manila, Philippines.



Social expectations for men and women are not the same in every society or cultural group and can change over time. For example, in some societies, women are responsible for agricultural work while in other societies, it is men who are responsible for this work. In some social groups, men are expected to get paid work that provides for the family, while women are expected to take care of children and housework. You will be aware of these kinds of contrasts in your own community and may have quite different expectations of gender roles than your grandparents.

In most societies, these differences in gender roles mean that relationships between men and women tend to be unequal. Gender inequality is about women and men having unequal access and control over resources, such as unequal work and educational opportunities, and unequal access to health services. Gender inequality is also about men and women being valued or respected differently.

UNESCO defines gender inequality as women (and girls) and men (and boys) having unequal conditions for realizing their full human rights and for contributing to, and benefiting from, economic, social, cultural and political development.⁵

Gender inequality is the main reason why women and girls are more vulnerable to HIV than men and boys. In many societies, women and girls generally have less control over their bodies and the power to make decisions about their own reproductive and sexual health. For example, they often have less power to make sure that sex is safe. They also may have less power than men and boys to decide who they have sex with and when they have sex.

How gender inequality creates higher risk factors for HIV infection

Gender inequality contributes to several conditions that make women and girls more vulnerable to HIV:

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- ▶ Economic vulnerability. Women and girls make up a disproportionate share of the world's poor. Women and girls with little access to and control of resources have less influence over their environment and may have less power to negotiate safe sex. Poverty can drive women and girls into sex work and prevent access to essential health services.
- ▶ Lack of education. This leads women and girls to have less access to information about HIV prevention, STIs, and reproductive and sexual health. They also have less access to related health services. In fact, the rate of HIV infection is much higher in out-of-school girls than girls who are attending school.⁶
- ▶ Double standards of sexuality. In many societies, it is acceptable for men to have multiple sex partners, while women are expected to not have premarital sex and to be faithful to one partner. Such social and cultural expectations make it difficult for women and girls to openly find out about sexual and reproductive health, and to get tested and treated for STIs such as HIV.
- ▶ Violence against women. Violence against women and girls exists in all societies. It can happen in public places such as the workplace and schools, as well as in the home. A woman or girl who is experiencing sexual or physical violence from a man or boy, whether or not she may know him, is far less in a position to negotiate any kind of safe sexual practice.

5. UNESCO (2006) *A Toolkit for Promoting Gender Equality in Education*, Bangkok: UNESCO Asia and Pacific Regional Bureau for Education.

6. The Global Coalition on Women and AIDS, UNAIDS. (2005) *Educate Girls Fight AIDS*. Geneva: UNAIDS.



Women face greater stigmatization

Stigma and discrimination are among the worst consequences of HIV and AIDS. Women and girls suffer from this more than men because of cultural double standards regarding sexuality. If a man becomes infected with HIV, people say he was foolish or unlucky. If a woman or girl is living with HIV, it is often assumed that she was promiscuous and therefore viewed as a bad person.

Education and HIV prevention

Growing evidence shows that girls who stay in school are less likely to be infected by HIV. When girls stay in school through the secondary level, the chances of them becoming infected with HIV as compared to their out-of-school counterparts are significantly lower. With each year of education, young women become more knowledgeable, independent and better equipped to make good decisions about their sexual lives. Greater knowledge and education also leads to greater income opportunities, which helps to keep women and girls out of the trap of poverty that can lead to HIV and AIDS.

HIV preventive education helps school children to acquire the knowledge, skills and attitudes needed to help them adopt healthy lifestyles and practices, which will decrease their vulnerability to HIV infection.



Illustrations: Krishna Gopal Shrestha



What needs to be done?

- ▶ Promote and protect the human rights of women and girls.
- ▶ Advocate for gender equality.
- ▶ Promote zero tolerance of all forms of violence against women and girls.
- ▶ Ensure that women and girls have access to knowledge, tools and services for HIV prevention and reproductive health so they can make informed choices about their sexual and reproductive health.
- ▶ Ensure equal and universal access to HIV and AIDS care, treatment and support programmes.
- ▶ Don't stigmatize women and girls living with HIV. Support their organizations and networks.
- ▶ Support Education for All.

What schools and teachers can do

- ▶ Give teachers the training, teaching and learning materials and other support they need to teach HIV preventive education effectively in school.
- ▶ Create safe and supportive learning environments for students, especially girls, by instituting zero tolerance for sexual exploitation and violence. Implement clear guidelines for dealing with such allegations.
- ▶ Do whatever it takes, including eliminating school fees, to keep girls in school.
- ▶ Involve parents and the community so they are sensitized to, and support, HIV preventive education.
- ▶ Provide lifeskills-based education as this supports the participation of all students across the school environment.
- ▶ Ensure that teachers avoid gender stereotypes, promote girls' leadership and self-esteem, and actively promote gender equality in the school setting at all times.
- ▶ Include age-appropriate information on sexual and reproductive health and HIV preventive education.
- ▶ Connect to out-of-school services for counselling and reproductive health.

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Gender by the Numbers

- ▶ A review of 113 studies from five continents found that teaching HIV and AIDS education in schools was effective in reducing early sexual activity and high-risk behavior.⁷
- ▶ Worldwide, 115 million children are not attending primary-school, the vast majority of which are girls.⁸
- ▶ Surveys in 11 countries showed that women with some schooling were five times more likely than uneducated women to have used a condom the last time they had sex.⁹
- ▶ A study of eight sub-Saharan African countries showed that women with eight or more years of schooling were up to 87% less likely to have sex before the age of 18 compared to women with no schooling.¹⁰
- ▶ In South-East Asia, only 13% of young women were able to correctly identify two prevention methods and three common misconceptions about HIV and AIDS.¹¹
- ▶ In Viet Nam and Cambodia, 30% of young women believed that HIV could be contracted by supernatural means. Nearly 35% believed a healthy-looking person could not be living with HIV.¹²

Vulnerability

UNAIDS defines vulnerability as the likelihood of being exposed to HIV infection because of a number of factors or determinants in the external environment that are beyond the control of a person or particular social group. Women and girls, particularly from poor communities, are among those with a pronounced vulnerability to HIV infection as a result of unequal gender relations.¹³

7. Ibid.

8. Ibid

9. Ibid.

10. Ibid.

11. UNAIDS/UNFPA/UNIFEM. (2004) *Women and HIV/AIDS: Confronting the Crisis*. A joint report by UNAIDS/UNFPA/UNIFEM. Geneva: UNAIDS.

12. Ibid.

13. UNAIDS Interagency Task Team on Gender and HIV and AIDS, 2005.



Theme Sheet: Men Who Have Sex With Men (MSM)



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Cover photo: Men in Thailand discuss the importance of proper condom use.

Theme Sheet:

Men Who Have Sex With Men (MSM)

This sheet looks at the vulnerability of men who have sex with other men. This is an issue that is often neglected in educational practice, which tends to focus on heterosexuality as the socially-accepted norm. Consequently, it needs to be addressed carefully in school, ideally through the official curriculum.

Men who have sex with men – and women

M-S-M stands for 'men who have sex with men.'¹ In the context of talking about HIV and AIDS, we don't use the terms homosexual or gay because there are MSM who also have sex with females. They don't necessarily think of themselves as homosexual or gay. 'Men who have sex with men' is a term that identifies a behaviour.

Many MSM do identify themselves as gay or homosexual, and are proud of their identity. In some countries, strong gay rights movements have emerged, and discrimination against people because of their sexual orientation is illegal.

There are also 'women who have sex with women' (WSW).² They may choose to identify themselves as gay or lesbian. For biological reasons, they are not at risk of getting HIV and AIDS through sexual activity unless they also have sex with men.

Fairness and sensitivity in teaching

Sexual diversity is part of human nature. It exists in every country and culture, regardless of whether or not some people choose to recognize and accept this fact.³

People generally become aware of their sexuality and sexual orientation during their school years. This can be an exciting time of discovery and experimentation. It can also be a confusing time full of questions, doubts and insecurities – especially if young people have a sexual orientation that is not the same as the majority of people around them.

1. The term "men who have sex with men" is preferred by UNESCO. MSM is 'an inclusive public health term used to define the sexual behaviours of males having sex with other males, regardless of gender identity, motivation for engaging in sex or identification with any or no particular community' (see www.msmasia.org) Some other UN agencies also use the term "males who have sex with males." In both instances, the term also refers to boys who engage in this behaviour, as some people begin having sexual relations before the age of 18. Just as with MSM, WSW also refers to girls, as some begin their sexual experiences before the age of 18.
2. See http://en.wikipedia.org/wiki/Women_who_have_sex_with_women
3. UNICEF EAPRO HIV/AIDS Officers and Child Protection Officers Training, Manila, May 2006. Presentation by Dr. Carol Jenkins.



Teachers need to be aware of, and sensitive to, sexual diversity. Some of their students are probably exploring or discovering MSM behaviour. When teaching about sexuality, human relations, reproductive health, HIV and AIDS, it is important to include information about MSM to enable these boys to prevent HIV infection.

MSM have the same rights as others to the knowledge and tools they need to protect themselves from health risks. An MSM is someone's son. A WSW is someone's daughter. As with other young people, they have the right to grow to their fullest potentials as contributing members of society, and should be encouraged to do so.

MSM should not be stigmatised

MSM are often the targets of stigma and discrimination, and one reason for this is because people think their sexual orientation is abnormal. This is not so. Studies show that MSM exist in every nation, and every society.⁴ There are no exceptions. MSM may be less visible in some countries because of stigma and discrimination, but they are there.

On average, roughly 4% of men in most countries identify themselves as always having sex with other men.⁵

On average, somewhere between 12% and 15% of men in most countries identify themselves as having had sex with another man at some point in their lives.⁶

Some men, especially young men who are school age, will experiment with MSM behaviour during the process of discovering their own sexuality. Not all will go on to identify themselves as gay or homosexual, or continue MSM behaviour later in life.

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The HIV situation among MSM

- The HIV and AIDS situation among MSM is alarming. In places where HIV infection rates in communities of MSM have been measured, those rates have been very high. A recent study of some groups of MSM in Bangkok, Thailand, found that 30.7% were living with HIV in 2007.⁷ In Phnom Penh, Cambodia, a 2000 survey found 15% were infected. A 2003 study found that 18.8% were infected in Mumbai, India.⁸

Why MSM are vulnerable to HIV

MSM are especially vulnerable to HIV infection for cultural and biological reasons. Many governments ignore MSM in their HIV prevention programmes, and so MSM don't get the information or services they need in order to know how to protect themselves.

This can also extend to school curricula and, in particular, the subject of HIV preventive education, which includes sex education. These subjects need to be taught for the protection of all young people. Leaving MSM out of these topics and discussions may put the lives of these young people at risk.

4. Ibid.

5. Ibid.

6. Monitoring the AIDS Pandemic Network. (2005) *Male-Male Sex and HIV/AIDS in Asia*. Washington, D.C.: MAP Secretariat.

7. Ministry of Public Health of Thailand/US Center for Disease Control study; publication forthcoming in 2008.

8. Monitoring the AIDS Pandemic Network. (2005) *Male-Male Sex and HIV/AIDS in Asia*. Washington, D.C.: MAP Secretariat.

Myths about MSM

Most MSM are effeminate and so it's easy to know who they are.

While some MSM have effeminate mannerisms, many do not. Some, in fact, are extremely macho or masculine. Those who have effeminate mannerisms also are not necessarily transgender – they do not wish to be women.

MSM are usually hairdressers/ designers/ work in other creative or feminine jobs.

Some do, but many don't. MSM have been world boxing champions and excel in other sports. They are soldiers – even generals – policemen, doctors and professors.

All MSM have HIV and AIDS.

Even though HIV prevalence rates are alarmingly high among MSM, the vast majority do not have HIV and AIDS.

Male-male sex is safer than male-female sex.

Most MSM engage in anal sex. The anus is not naturally lubricated, and so during sex small cuts and tears can occur, allowing the HIV virus – if it is present in one partner – to enter the blood stream of the other partner. Unprotected anal sex is the riskiest form of sex.

Most clients of male sex workers are foreigners.

In every country, most clients of male sex workers are local people.

Sexual predators and paedophiles are usually MSM.

This is simply not true. While some MSM fall into this category, police records show that most sexual predators and paedophiles are heterosexual and most victims are female.

HIV and AIDS is a gay disease.

Anyone can get HIV and AIDS. No one is immune, and it does not affect just one group of people.

Stigma and discrimination also inhibit MSM from seeking information on their own. Many do not wish to reveal their sexual orientation to others for fear of social repercussions. This may also inhibit them from seeking and accessing sexual health services.

Biological factors also make MSM vulnerable to HIV, particularly those MSM who engage in anal intercourse. The anus does not naturally produce lubricants for sexual activity, and so during intercourse it may sustain small tears or abrasions that expose blood vessels. This provides a direct pathway for the virus to enter the bloodstream if the partner is living with HIV and the sex was unprotected. Anal intercourse, whether between men or between men and women, is a high-risk behaviour. Because female-female sex does not often involve anal intercourse, WSW are at lower risk of HIV infection.

Men are also more likely to have casual, non-committal sex than women. In a scenario where men are having sex with men, it follows that there will probably be more casual sexual activity taking place. Coupled with lack of knowledge about safe sexual practices, there will then be more opportunities for HIV infections to be transmitted.



MSM and the broader society

Many MSM also have sex with women. Some are married, and some have girlfriends. Some are students. Their female partners may know nothing about their MSM behaviour.

If a man has unprotected sex with another man who is living with HIV, he may become infected. If he then has unprotected sex with his girlfriend, she may become HIV-positive. If she becomes pregnant, her baby may be born HIV-positive. If she has unprotected sex with another man, he may become HIV-positive.

These are some of the pathways through which HIV is spread. They are not uncommon.

People usually become aware of their sexual orientation when they are young, and often that is when they have their first sexual experiences. Schools and teachers, therefore, need to be aware of, sensitive to, and accepting of MSM.

Young MSM are like other young people: they are full of potential to become valuable and contributing members of society. As with other young people, they should be protected and nurtured. MSM are soldiers, scientists, sports stars, politicians, policemen and doctors, among other professions. No society can afford to lose the contributions of these people through discrimination or neglect.

What needs to be done

- ▶ MSM must be included in national HIV and AIDS prevention, treatment care and support programmes.
- ▶ Health care systems must not discriminate. They must be MSM-friendly.
- ▶ Groups and organizations that can reach MSM with information and health care services must be allowed to work free of harassment from law enforcement.
- ▶ Health care services should promote and provide lubricants and condoms.
- ▶ Public service campaigns should raise awareness and acceptance of MSM and reduce stigma and discrimination.
- ▶ MSM must be afforded all the same rights and protections as other members of society.

What schools and teachers can do

- ▶ Teach HIV preventive education, including sex education and reproductive health.
- ▶ Include the subject of MSM in these lessons and discussions.
- ▶ Accept the fact that there are MSM among your students and possibly among colleagues.
- ▶ Combat prejudice. Promote tolerance and acceptance, identify and dispel myths.
- ▶ Use a lifeskills-based approach to school subjects.
- ▶ Link your school to outside services and HIV-service organizations that are MSM-friendly or MSM-oriented.
- ▶ Enact and enforce a zero-tolerance policy about violence against MSM.



Transgender People

Transgender people are those who were born into a body with the wrong sex. Some try to live as a member of the opposite gender, and may have sexual reassignment surgery to become a member of the opposite sex.

In most countries, transgender people are often discriminated against even more strongly than MSM. Young transgenders, who are just discovering their sexual identities, can suffer terribly because of confusion, stigma and discrimination.

Rejection by society leads some to become sex workers. Rejection also can have psychological effects. Craving love and approval, some transgenders can be too willing to please partners and clients, or unwilling to assert themselves and insist on safe sexual practices. This puts them at greater risk of HIV infection.

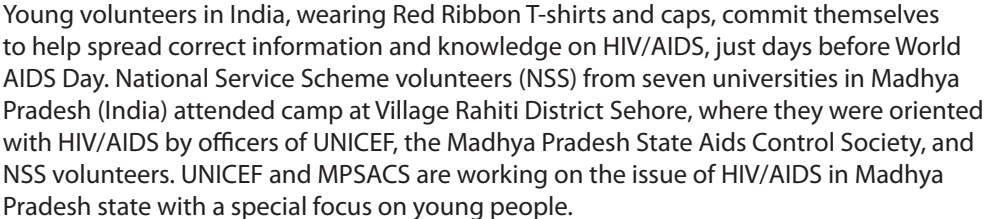
As with MSM, transgenders exist in every society. They need acceptance, care and support, and should be included in HIV preventive education programmes.



Theme Sheet: Injecting Drug Use



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Cover photo:  Young volunteers in India, wearing Red Ribbon T-shirts and caps, commit themselves to help spread correct information and knowledge on HIV/AIDS, just days before World AIDS Day. National Service Scheme volunteers (NSS) from seven universities in Madhya Pradesh (India) attended camp at Village Rahiti District Sehore, where they were oriented with HIV/AIDS by officers of UNICEF, the Madhya Pradesh State Aids Control Society, and NSS volunteers. UNICEF and MPSACS are working on the issue of HIV/AIDS in Madhya Pradesh state with a special focus on young people.

Theme Sheet: Injecting Drug Use

Young people – from all levels of society – are prone to experimenting with new and risky behaviours. Teachers may not even realize that some of their students have begun experimenting with drugs. Drug taking, especially injecting drug use, can in turn significantly increase vulnerability to HIV and AIDS. Drugs and substance abuse education should be an important component of all education programmes for adolescents.

HIV rates soar via IDU

I-D-U stands for injecting drug use, which means using needles or syringes to inject drugs such as heroin, morphine, cocaine or methamphetamines into the bloodstream. Among all the groups most vulnerable to HIV, infection rates are highest among people who inject drugs.¹

Injecting drug use is a key driver of the HIV and AIDS epidemic in Asia and the Pacific.² In many countries in the Asia-Pacific region, HIV first appeared among people who inject drugs and sex workers before seeping into the general population.

IDU-driven HIV epidemics often start with drug users who are young, male and sexually active.³ Some are in school when they start.

Why people who inject drugs are vulnerable to HIV

The practice of injecting drugs very often involves the sharing of injecting equipment. When a needle or syringe is injected into a person's blood vessel, some of that person's blood remains in the needle or syringe after it is withdrawn. If that blood contains a virus, such as HIV, the needle or syringe becomes contaminated.

When that contaminated needle or syringe is used by another person, the infected blood will be injected into that person. The most efficient method of transmitting HIV is to inject it directly into a person's bloodstream. Sharing contaminated injecting equipment does exactly that. It is even more effective in transmitting HIV, than unprotected sex.

People may share contaminated needles because they lack access to their own injecting equipment, because they do not have the money to buy new needles and syringes, or simply because they are not aware of the related risks. In some settings, sharing needles has been found to signify bonding and friendship between people who inject drugs.

1. Monitoring the AIDS Pandemic Network. (2005) *Drug Injection and HIV/AIDS in Asia*. Washington, D.C.: MAP Secretariat.

2. Ibid.

3. WHO/UNAIDS/UNODC. (2005) *Evidence for Action on HIV and AIDS and Injecting Drug Use. Policy Brief: Antiretroviral Therapy and Injecting Drug Users*. Geneva: WHO.



All drug use increases vulnerability to HIV

All mind-altering drugs, whether injected or not, can make people more vulnerable to HIV infection. When intoxicated, people make different decisions or engage in risk behaviour than they would make in a sober state. They may, for example become less likely to insist on condom use. Thus, alcohol can also be considered as a mind-altering drug.

People who inject drugs live among us

Drug users don't live in isolation. In the early stages of the epidemic, HIV may infect mainly people who inject drugs and other key populations vulnerable to HIV – but it doesn't remain contained there. People who inject drugs have wives, husbands, children, girlfriends and boyfriends, or casual sexual relationships with multiple partners who may not be using drugs. Through sexual relationships, people who inject drugs may pass on the HIV virus to others. They may also pass it on through parent-to-child transmission.

It is a common misconception that injecting drug use dampens sexual desire or ability, and that people who inject drugs are not very sexually active. In fact, surveys in Asia and the Pacific show that these people are more sexually active than many other population groups.⁴ Much of this sex is commercial sex – sex that is bought or sold.

Sex work and drug use

While the majority of sex workers do not inject drugs, a very high percentage of people who inject drugs sell or buy sex.⁵ Because sex workers have more partners than most other people, the most dangerous combination of risk behaviours is injecting drug use and sex work.

Surveys around Asia and the Pacific show that in many countries, more often than not, this sex is unprotected.⁶ This creates more opportunities and pathways for the virus to spread.

Treat, don't punish

Drug use or addiction is often viewed by many in society as a law enforcement issue. Others say it is primarily a health problem; drug use and addiction can be treated.

As a consequence of viewing drug use as a law enforcement issue, drug users have relatively high rates of imprisonment. This only worsens the HIV epidemic.

HIV spreads rapidly in settings where people are confined in close quarters for long periods of time. Prisons, jails, juvenile corrections facilities, reform schools and remand homes are such places. Most people confined in such places are eventually released. If they have become infected while confined, they may infect others when they return to their communities. Prisoners may also receive visits from wives, husbands, girlfriends or boyfriends, during which they may spread the virus to those who are not incarcerated. Preventing the spread of HIV in prison settings, therefore, helps protect the general population.

4. Monitoring the AIDS Pandemic Network. (2005) *Drug Injection and HIV/AIDS in Asia*. Washington, D.C.: MAP Secretariat.

5. Ibid

6. Ibid



In prison or confinement settings, MSM behaviour is common and often unprotected. Violence and forced sex are also frequent occurrences. Furthermore, although it is against the rules, drugs and injecting equipment are available in many prisons. As injecting equipment can be difficult to get inside prison, needles and syringes are often shared. They are also usually contaminated with HIV and other infections. This makes prisons a favourable context for HIV transmission.

For the sake of public health and stopping the spread of HIV, drug users should be treated, not punished.

Education and drug use

As many IDU-driven HIV epidemics start with young people who inject drugs, school is an important place to address this problem. Schools can respond to students and assist them to get the support and services they need to deal with drug problems. Research shows that a safe and supportive school environment increases protective factors and reduces the risk of drug problems developing. Education helps build resilience.

Teachers and school staff can play a critical role in intervening early with students to prevent the start or escalation of drug use problems and the risks of HIV. Teachers need to be trained to assume that role.

Abstinence from drug use is clearly the best way to prevent HIV transmission and should therefore be encouraged as much as possible. However, promoting abstinence and penalizing drug use are unlikely to curb all use of injecting drugs.

Young people need honest and accurate information about drugs, the pleasures and dangers of injecting drugs and substance abuse, the risks of unprotected sex and the facts about HIV and AIDS.

Scare tactics don't always work. They can make drug use seem attractive as a way to rebel against adults. Good quality education leads to people thinking through their choices.

Drug education programmes deal with the areas of peer pressure, addiction, health effects and social implications of drug use, legal issues and outside services and agencies that can assist in any situations.

While peer pressure can lead to drug use, peer networks can also be useful in relaying help and information to drug users, and in alerting teachers as to who is vulnerable or at risk.

Drug users also need education. They have a right to know how to protect themselves, as well as their sexual partners and unborn children, from HIV.

What needs to be done

- ▶ Provide treatment for drug dependence, including substitution drug treatment. People who use drugs regularly may have developed a physical or psychological dependency on the drugs; this is a medical issue and problem that can be addressed with medical treatment and counseling.
- ▶ Provide people who inject drugs with information on risk reduction, HIV and AIDS education, and referral to services.
- ▶ Improve access to hygienic materials such as clean needles and syringes, bleaching equipment, and condoms.

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- ▶ Offer voluntary and confidential counselling and testing for HIV.
- ▶ Treat sexually transmitted infections of people who inject drugs.
- ▶ Make antiretroviral therapy available for those in need.
- ▶ Educate key populations who are vulnerable to HIV, such as young people, prisoners and sex workers who inject drugs.

What schools and teachers can do

- ▶ Provide HIV preventive education.
- ▶ Provide life skills-based drug education programmes.
- ▶ Raise the issue of drugs, and give honest and accurate information.
- ▶ Provide counselling for students.
- ▶ Link the school to outside support services.
- ▶ Develop peer networks to reach those at risk or already using drugs, and provide them with information and help.
- ▶ Develop a school policy and procedures for dealing with students with drug dependency and related problems.
- ▶ Train teachers in how to recognise and deal with drug use among students and related problems.
- ▶ Involve parents and the community where appropriate.

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IDU by the Numbers⁷

- ▶ In Malaysia, 55% of people found to have HIV between 1998 and 2001 were people who inject drugs.
- ▶ In Chennai, India, 64% of people who inject drugs were living with HIV in 2003.
- ▶ In Ho Chi Minh City, Viet Nam, about half of all sex workers who injected drugs were found to be living with HIV in 2001.
- ▶ In the Sichuan province of China, 5% of street-based sex workers inject drugs and report low levels of condom use with customers.
- ▶ In the Kalimantan province of Indonesia, health officials estimate that of the 3,000 people living with HIV, 2,300 of them are people who inject drugs.
- ▶ In Surabaya, Indonesia, nearly 70% of males who inject drugs and who buy sex do not consistently use condoms.

7. Ibid



Theme Sheet: **Orphans and Vulnerable Children**



Sri Lanka © UNESCO/R. Dominique

Cover photo: Reading, books, young school children.
Primary Education.

Theme Sheet: Orphans and Vulnerable Children

AIDS orphan population increases

There are half a million children orphaned by AIDS in the Asia-Pacific region.¹ In ten years, the number could be three times higher unless nations scale up their HIV and AIDS programmes to effective levels.² A child, as defined by the Convention on the Rights of the Child, is any human under 18 years of age. A child orphaned by AIDS is a child who has lost one or both parents to AIDS-related illnesses.

Of the 8 million people living with HIV in the Asia-Pacific region, half a million are children.³ This number will also rise if governments maintain the current levels and reach of their prevention programmes. Prevention programmes need to be scaled up to national levels.

These programmes must also have components designed specifically for children. Children require different prevention, treatment, care and support approaches than adults. All too often, programmes ignore children, leading UNICEF to say, "Children are the missing face of AIDS."⁴

A child may be HIV-negative and his or her parents still alive, yet they can still be affected if they have a parent, family member or caregiver living with HIV. They may be affected if their neighbours or friends are living with HIV. The psychological, social, behavioural and economic effects upon children living in these circumstances can be wide-ranging and severe.

Teachers and schools need to be aware

It is especially important for teachers to be aware of the impact of HIV and AIDS on children. Teachers can play a valuable and crucial role in recognising the needs of children who are affected by HIV at home and providing them with understanding and support at school. They can help break the cycle of vulnerability that puts these children at risk of contracting HIV in the future.

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1. UNICEF "Scaling Up The Response for Children East Asia and Pacific Regional Consultation on Children and HIV and AIDS," 22-24 Mar 06, Hanoi, Viet Nam.
 2. Ibid.
 3. Ibid.
 4. Ibid.



Certain children are more vulnerable

Children living in difficult circumstances and those involved in risk-taking behaviours are more vulnerable to HIV. Children living with a parent, sibling or caregiver who has HIV may become depressed or suffer other emotional disturbances because of the burden of caring for a relative who is ill, or because of stigma and discrimination from the community.

Children may be infected through sexual abuse. Street children are extremely vulnerable to this because they are out-of-school and usually lack an adult guardian or caregiver.

Children living in the aforementioned circumstances suffer from emotional pain. They may take drugs or alcohol to deal with their pain. With their judgement impaired, they are more vulnerable to rape or engaging in unsafe sex. In this way, they are at greater risk of contracting HIV.

Young people in the region are directly engaged in risk-taking behaviours such as injecting drugs, sex work, or having unprotected male-male sex.⁵ Some researchers believe the most effective way to stop the spread of the epidemic among all children is to target the major share of resources and interventions at these children.

Poverty also enhances vulnerability. The need to work to support one's family or the inability to pay school fees keeps children from getting an education. Studies show that children who stay in school are less likely to be infected with HIV.⁶

Children with disabilities, minority children and stateless children are also vulnerable, as they are sometimes refused the right to receive education and access to health care systems.

Parent-to-child transmission

Some children are already living with HIV or AIDS. Usually this is because a mother living with HIV has passed on the virus to her child during pregnancy, delivery or through breastfeeding. This is called parent-to-child transmission because children are usually infected due to the actions of their parents. Many people living with HIV are unaware of their status because there are no obvious symptoms for many years. They only realize later when they get sick. By then, their child may be carrying the virus, as well. Men and women both have a responsibility to prevent HIV transmission to their offspring.

Effects upon children's development

Children suffering the trauma of parental loss or abuse may become emotionally withdrawn, despondent, fearful of further loss or abandonment, or angry at the injustice of their situation. These feelings often lead to destructive and high-risk behaviours. Difficulty concentrating in class, social isolation and violent outbursts are common manifestations of the grief and anxiety these children experience. Adolescence is a particularly turbulent time: the loss of parental guidance combined with a sense of hopelessness or depression can lead young people to engage in reckless and often self-destructive behaviour, such as substance abuse or unsafe sex.

5. UNICEF/UNFPA/UNESCO. (2007) *Responding to the HIV Prevention Needs of Adolescents and Young People in Asia: Towards Cost-Effective Policies and Programmes*. Bangkok: UNICEF.

6. Global Coalition on Women and AIDS, UNAIDS. (2005) *Educate Girls Fight AIDS*. New York: UNAIDS.



The loss of material support that a parent provides exposes children to increased health risks. Malnutrition in the early stages of a child's life can cause irreversible stunting and cognitive damage, impeding a child's healthy physical and intellectual development.

Older children may find themselves having to carry the burden of providing for an ailing parent or dependent siblings. Working long hours to support themselves and their families can mean they are unable to keep up with the demands of schooling. Poor classroom performance, sporadic attendance and increased drop-out rates are symptomatic of the material deprivation that many orphans and vulnerable children (OVC) experience.

Stigma and discrimination

With so many myths and misconceptions surrounding HIV and AIDS, children may be ostracized, rejected or isolated at a time when they need care and support more than ever. People, and especially their peers, may believe they are at risk of being infected by these children. Some may believe these children or their parents were infected or are affected because they are "bad" people.

Teachers and schools have a vital and tremendous role to play in reducing stigma and discrimination against orphans and vulnerable children. They can influence the ideas, attitudes and behaviours of children in their care. More than that, teachers are role models and respected members of the community. They can also influence the ideas, attitudes and behaviour of parents and others.

No one can defeat stigma and discrimination alone. It requires partnerships and collaborative efforts by schools, teachers, parents, religious and spiritual leaders, business people and community leaders. As a valued community institution, schools can be a nexus around which these collaborative efforts are organized.

3

What governments can do

- ▶ Scale up pilot projects to national programmes that provide comprehensive HIV and AIDS prevention, treatment, care and support.
- ▶ Sign and honour international agreements that protect children and provide for those living with HIV, such as the Convention on the Rights of the Child.
- ▶ Provide free antiretroviral therapy for all children living with HIV.
- ▶ Enact legislation to make discrimination because of HIV and AIDS illegal.
- ▶ Run public service campaigns to raise awareness and fight stigma and discrimination.
- ▶ Design HIV and AIDS prevention, treatment, care and support programmes with components geared towards children.
- ▶ Involve children in the design and implementation of these programmes.
- ▶ Provide comprehensive paediatric HIV and AIDS care for children.
- ▶ Improve surveillance and data collection about children and HIV and AIDS to more effectively target programmes and interventions.
- ▶ Improve institutions that care for orphans, while recognizing that institutions should be the last resort.



- ▶ Provide more funding for community-based care for orphans.
- ▶ Support Education for All. Eliminate and outlaw school fees.
- ▶ Fund daycare for children when they are not in school.

What communities can do

- ▶ Support HIV and AIDS education and stigma reduction in schools and the community.
- ▶ Raise funds to keep children living with or affected by HIV and AIDS, or vulnerable to HIV, in school.
- ▶ Provide care, support and foster homes for children orphaned by AIDS – children want to stay in their communities.
- ▶ Work with schools, religious leaders and faith-based organizations to raise awareness and understanding, and reduce stigma and discrimination.
- ▶ Organize meetings to discuss these issues.
- ▶ Invite organizations of people living with HIV and AIDS to meet members of the community and discuss these issues.
- ▶ Organize child-watch networks to monitor and reach out to children and families at risk or vulnerable to HIV through poverty, abuse or risky behaviours.
- ▶ Provide day care for children when they are not in school.

4

What families can do

- ▶ Take in relatives' children who have been orphaned by AIDS – children want to stay with their families.
- ▶ Learn the facts about HIV and AIDS, and teach them to your children.
- ▶ Teach your children never to discriminate against or stigmatize another child or family who has been living with or affected by HIV and AIDS, or is vulnerable to HIV.
- ▶ Support HIV and AIDS education in your local schools.
- ▶ Do everything within your power to keep your children in school.
- ▶ Communicate and establish relationships with your school, its teachers and spiritual leaders to strengthen the community safety net for children.
- ▶ Seek outside counselling and services if your child or family needs them.



What religious institutions can do

- ▶ Don't treat children affected by AIDS differently than children orphaned by other causes.
- ▶ Embrace children living with or affected by HIV and AIDS – this provides a strong, positive model for the community and helps dispel fears.
- ▶ Use the power of your voice and moral authority to openly discuss HIV and AIDS. Appeal to members of the community not to stigmatize or discriminate.
- ▶ Use your institution's funds to support the education of children living with or affected by HIV and AIDS, and vulnerable to HIV.

What schools and teachers can do

- ▶ Eliminate school fees so that orphans and vulnerable children can stay in school.
- ▶ Use whatever funds you can find to support poor children, orphans and vulnerable children's ability to stay in school by providing meals, books and other material needs.
- ▶ Openly discuss stigma and discrimination related to HIV and AIDS so that other children understand the issues.
- ▶ Do not tolerate stigma or discrimination in your school.
- ▶ Teach life skills-based education so children understand HIV and AIDS, how they can prevent themselves from being infected, and how they can make good choices about their lives.
- ▶ Link your school to outside services to provide prevention, treatment, care and support services for children living with or affected by HIV and AIDS, and vulnerable to HIV.
- ▶ Link your school to any poverty alleviation programmes and services to keep poor children in school, as poverty heightens vulnerability to HIV and AIDS.
- ▶ Invite people living with HIV and AIDS to meet with and talk to students so that their fears are dispelled.
- ▶ Reach out to parents and other community members to support your efforts.
- ▶ Train teachers to recognize and deal with children who may be experiencing emotional or other problems because of HIV and AIDS or the effects of HIV and AIDS on their families.
- ▶ Make sure school counsellors have been trained to deal with these issues.
- ▶ Organize peer networks for outreach to affected and vulnerable children and children engaged in risky behaviours.

5



Orphans and Vulnerable Children by the Numbers⁷

- ▶ There are about half a million children orphaned by AIDS in the Asia-Pacific region.
- ▶ More than 11,000 children were newly infected with HIV during 2005 in the Asia-Pacific region.
- ▶ About 8,500 children in the region were in immediate need of antiretroviral therapy in 2005.
- ▶ Paediatric treatment for HIV and AIDS can boost annual survival rates by anywhere from 50% to 95%.

7. UNICEF. (2006) *Report on the East Asia and Pacific Regional Consultation on Children and HIV and AIDS*. Bangkok: UNICEF for East Asia and Pacific Regional Office.



Linking Schools to HIV and AIDS-Related Services



Philippines © 2005 Rick M. Reyes, Courtesy of Photoshare

Cover photo: Officers, members and supporters of the Baguio City AIDS Watch Council (BCAWC) light candles around a ribbon made of red roses remembering those who are suffering and dead from AIDS. The May 16, 2005 Baguio AIDS Candle Light Memorial had the theme “Turning Remembrance Into Action” and was held at the Peoples Park in Baguio City, Philippines.

Linking Schools

Preventive education needs to be linked to the provision of HIV and AIDS-related services for young people. It can inform students about the importance of such services and about where they can be accessed. Schools can be instrumental in raising both demand for services and their uptake.

Partnerships are crucial

Schools play an important role in the response to the HIV and AIDS epidemic, but they can't do everything. Partnerships between schools and outside services are crucial for young people to receive the utmost in protection and care.

Most communities have a range of health, welfare and other services that can provide people with information and tools for HIV and AIDS prevention, treatment, care and support. Some are government agencies, while others are non-governmental or private organizations. Most young people have no idea these services exist. They may also have fears about accessing them.

For the benefit of young people, it is important that schools are aware of these agencies and organizations, and establish relationships with them. Schools and teachers need to understand the services such organizations provide. When a student needs help that is beyond the capacity of schools, a simple referral to an outside service can be a life-saver.

Services need to be youth friendly

Not all services, particularly those delivered by some government agencies, are youth friendly. Services that are youth friendly understand the psychological and social issues relating to young people, along with the practical concerns of the services they provide. This means they respect young people's needs, especially for confidentiality, and deal with them in a non-judgemental way. If services are not youth friendly, then schools can advocate for them to adopt youth-friendly approaches and practices. Services aren't much good if young people don't know about them or are afraid to access them.



Types of HIV and AIDS-related services¹

Voluntary confidential counselling and testing (VCCT) – No response to the HIV and AIDS epidemic can be successful if people don't know their HIV status. Individuals who are living with HIV and need treatment can't get it if they don't know they have been infected. If they don't know they are HIV-positive, they may infect others. Services that offer VCCT are essential to meeting the needs of the individual and addressing the epidemic.

Generally, people should get tested for HIV regularly so that they know their HIV status and can make informed decisions. There are various types of tests that can determine whether or not someone is living with HIV. Most involve taking a blood sample, but there are other tests available in some locations.

From the time when a person has contracted HIV, there is a 'window period' of 3 to 12 weeks. The window period is the period between infection with HIV and the appearance of detectable antibodies to the virus. During the window period, people infected with HIV have no antibodies in their blood that can be detected by an HIV test. HIV can be passed on to another person during the window period even though an HIV test may not show that you are infected with HIV. However, the person may already have high levels of HIV in their body fluids such as blood, semen, vaginal fluids and breast milk. Because of this, a person should always use condoms when having any kind of sex.

It is therefore necessary to repeat an HIV test after the window period, since it can take up to three months for your immune system to ensure an accurate result from the test.

The words that are key here are consent, confidentiality and counselling. The problems of stigma and discrimination make informed consent and confidentiality absolutely imperative for anyone providing testing services. If people don't have faith or believe the results will be kept confidential, they won't use the service. Test results should always be given individually and in private. They should never be given in groups. In a group situation, it is impossible to maintain confidentiality. If results are not kept confidential, those who test positive may be rejected by families and friends, lose their jobs, be barred from school or even subjected to violence.

Pre- and post-test counselling is also a must. If someone learns they are HIV-positive, the psychological effects could be devastating. Some may even harm themselves or commit suicide. It is extremely important that any testing service provide qualified counsellors as part of their package. They can help those learning they are positive find out the facts about their condition and situation and how best to cope with it. They can also refer them to additional services they may need, such as where to get treatment. It is just as important that those who test negative for HIV also receive counselling. Many who test negative are so overjoyed or relieved at the result that they neglect counselling. However, they were most likely involved in risk-taking behaviours or situations that led them to fear they had been infected and to get tested. Counselling can give them the facts about the risks they are taking, and advice on strategies to avoid those risks. Without counselling, they may be back before long, filled with fear that they have been infected and seeking another test.

1. Adapted from www.unaids.org/en/MediaCentre/References/



Psycho-social support and counselling – There may be students who are already living with HIV, know it and are having a difficult time coping. There may also be students who have a positive or ill member of their household and are having difficulty coping with that. They may need more extensive counselling than can be provided in a school setting. Teachers and schools need to know where this counselling is available in their area.

Reproductive health services – Many clinics offer reproductive health services. These can be good places for young people to obtain contraceptives, especially condoms, and information about HIV, other sexually transmitted infections and how to avoid them. Some NGOs involved in HIV prevention also distribute condoms. Both men and women are welcome at reproductive health clinics and should be encouraged to make use of them, either on their own or with their partners. Many, however, may still be reluctant to visit a reproductive health clinic, so it would be helpful if schools and teachers knew which NGOs operating in their area distribute condoms.

STI or sexually transmitted infection clinics – These clinics can test people for a variety of sexually transmitted infections. Research shows that having a sexually transmitted infection increases a person's susceptibility to HIV. Tests and results should be confidential. Many reproductive health clinics also offer STI testing.

Antiretroviral therapy – Those who can access antiretroviral therapy, or ART, can live for many years, even decades, with HIV. Antiretrovirals (ARVs) are drugs which slow down the reproduction of the virus, reduce viral load (the amount of virus present in the body) and work to repair the immune system. There are several drugs which do this, but for ART to be effective, they must be taken in combination every day for the rest of the patient's life. The earlier a person starts ART the more effective it will be, which is another reason it is important for people to know their status. Patients on ART suffer fewer illnesses and lead relatively normal lives.

There are several problems, however, with ART. Chief among them are cost and availability. ARVs are expensive and not available in many places that are usually less developed or poorer areas. Many groups are advocating reducing their cost and making them more available. Also, as they are relatively new, no one can be certain how long they will be effective, or if patients will develop resistance to them. Lastly, adherence is an issue. Patients must take ARVs every day or they will stop working.

Harm reduction and drug treatment programmes – If students are taking drugs, it is important for teachers to know what drug treatment programmes are available in their area. If they are injecting drugs, knowing where to find harm reduction programmes is essential. Harm reduction programmes distribute clean needles and other tools that can prevent people who inject drugs from getting HIV.

Services for key populations vulnerable to HIV – Particular sub-groups of young people, such as girls, ethnic minorities, drug users, men who have sex with men, sex workers or mobile populations, may be at heightened risk of HIV. If specific programmes or services for these sub-groups exist, it is imperative that schools make connections with them so that all young people can have access to culturally appropriate services tailored to their needs.



What schools and teachers can do

School principals and teachers are well placed to build links between schools and other relevant services by:

- ▶ Knowing what services are available in the local area for young people and connecting young people with them;
- ▶ Educating other teachers to do the same;
- ▶ Inviting service providers to talk to parents, teachers and students about the types of services their organization provides and the benefits of accessing such services;
- ▶ Establishing referral protocols and memorandums of understanding with relevant services; and
- ▶ Encouraging students to access such services where they do exist, and countering the shame and stigma which may be associated with the use of such services.



Facts and Figures



Cover photo: Pupils at a Bengali occidental school.

Facts and Figures

The facts and figures here will give you a brief overview of the magnitude of the AIDS epidemic in the world and in your region. Please note that these figures are estimates.

Worldwide¹:

- ▶ **33.2 million people** were living with HIV in 2007.
- ▶ **2.5 million people** were newly infected in 2007.
- ▶ **2.5 million children** (0-14 years) were living with HIV in 2007.
- ▶ By 2005, **25 million** had died from AIDS.
- ▶ By 2005, **15.2 million children** (0-14 years) had lost one or both parents due to AIDS.
- ▶ **Women** accounted for **50% of adults** living with HIV in 2007.
- ▶ **330,000 children** under 15 years of age died of AIDS-related deaths worldwide in 2007.
- ▶ The economic loss is estimated to account for more than **20 per cent of GDP** in the worst affected countries by 2020.
- ▶ **2.1 million** AIDS-related deaths in 2007.
- ▶ **420,000 children** (0-14 years) were newly infected with HIV in 2007.

1

1. UNAIDS. (2006) *2006 Report on the Global AIDS Epidemic: A UNAIDS 10th Anniversary Special Edition*. Geneva: UNAIDS.
UNAIDS/WHO. (2007) *2007 AIDS Epidemic Update*. Geneva: UNAIDS.



In Asia and the Pacific:

- ▶ **4.9 million people** were living with HIV by the end of 2007.²
- ▶ **440,000 adults and children** were newly infected in 2007.³
- ▶ **300,000 people** died from AIDS-related illnesses in 2007.⁴
- ▶ **450,000 children** are orphaned by AIDS, with at least as many living with a parent ill from AIDS.⁵
- ▶ Projected new infections in South and South-East Asia by 2010 if prevention is not scaled up: **10 million**.⁶

2



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- 2. UNAIDS/WHO. (2007) *2007 AIDS Epidemic Update*. Geneva: UNAIDS.
 - 3. Ibid.
 - 4. Ibid.
 - 5. UNICEF. (2006) *Report on the East Asia and Pacific Regional Consultation on Children and HIV and AIDS*. Bangkok: UNICEF for East Asia and Pacific Regional Office.
 - 6. Ibid.
 -



Further Reading

Afghanistan © UNESCO/Manocheh



Cover photo: Ferdeusi school classroom.

The mixture of age groups in the same class bears witness to the lack of schools for girls under the Taliban.

Further Reading

Basic Facts About HIV and AIDS

UNAIDS Fast Facts about AIDS

<http://www.unaids.org/en/MediaCentre/References/default.asp>

American Association for World Health: What We Can Do: Basic Facts about HIV and AIDS

<http://www.thebody.com/aawh/force99/basicfacts.html>

Canadian Strategy on HIV and AIDS: Basic Facts about AIDS

http://www.health.gov.ab.ca/public/dis_aid52.pdf

amFAR The Foundation for AIDS Research: Facts for Life

http://www.amfar.org/binary-data/AMFAR_PUBLICATION/download_file/3.pdf

The HIV and AIDS Situation in Asia and the Pacific

UNAIDS Report on the Global AIDS Epidemic

http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp

Commission on AIDS in Asia 2008 Report: Redefining AIDS in Asia Crafting an Effective Response

http://data.unaids.org/pub/report/2008/20080326_report_commission_aids_en.pdf

The Impact of HIV and AIDS on Families, Schools and Communities

HelpAge International: Community Support for Older People Affected by HIV and AIDS in Thailand

www.helpage.org/Worldwide/AsiaPacific/Keyprojects/SupportforolderpeopleaffectedbyHIVAIDS

UN Population Fund: Community Operated Youth Centres in Myanmar; A case study outlining how community centres for reproductive health and HIV prevention were started in a low resource setting where leaders were resistant to the idea.

http://www.unfpa.org.np/yfs/docs/lessonlearned_myanmar.pdf

United Nations Development Programme: The Impact of HIV and AIDS on Children, Families and Communities

<http://www.undp.org/hiv/publications/issues/english/issue30e.html>

1



The Role of Schools in Fighting HIV and AIDS

Family Health International: HIV/AIDS Prevention and Care in Resource-Constrained Settings: A Handbook for the Design and Management of Programs. (Click on Chapter 7 for Youth and Schools)
<http://www.fhi.org/en/HIVAIDS/pub/guide/HIVAIDSPreventionCare.htm>

UNESCO – FRESH (Focusing Resources on Effective School Health) Click on the link for HIV and AIDS and a library of articles on how to implement HIV and AIDS education and interventions in school settings.
www.unesco.org/education/fresh

International HIV/AIDS Alliance: Strengthening the Role of Schools
<http://www.aidsalliance.org/sw3570.asp>

UNESCO – HIV and AIDS in Asia: Human Rights and the Education Sector
http://www2.unescobkk.org/elib/publications/HIV_AIDS_EDU2/HIV_AIDS_EDU2.pdf

UNESCO - The Untapped Potential of School Directors to Strengthen School-based Responses to HIV and AIDS
http://www2.unescobkk.org/elib/publications/HIV_AIDS_EDU3/HIV_AIDS_EDU3.pdf

UNESCO - The Impact of HIV and AIDS on Children and Young People: Reviewing Research Conducted and Distilling Implications for the Education Sector in Asia
http://www2.unescobkk.org/elib/publications/073/Impact_of_HIV.pdf

Preventive Education

2

Building Your HIV-AIDS and Sexual Education Programme
HIV-AIDS Course, Chapter 9 - Building Your HIV-AIDS and Sexual...
<http://cnx.org/content/m13335/latest/>

- Education and HIV and AIDS: Sourcebook on HIV Prevention Programmes
www.schoolsandhealth.org/Sourcebook/sourcebook-complete.pdf

- UNESCO – EDUCAIDS Initiative
www.educaids.org

- UNESCO: Good Policy and Practice in HIV & AIDS and Education: Booklet 1 – Overview
www.unesdoc.unesco.org/images/0014/001461/146121e.pdf

- UNESCO: Good Policy and Practice in HIV & AIDS and Education: Booklet 2 – HIV & AIDS and Safe, Secure and Supportive Learning Environments
www.unesdoc.unesco.org/images/0014/001461/146122E.pdf

- UNESCO: Good Policy and Practice in HIV & AIDS and Education: Booklet 3 – HIV & AIDS and Educator Development, Conduct and Support
www.unesdoc.unesco.org/images/0014/001463/146308e.pdf

- UNESCO - HIV/AIDS and Education: A Toolkit for Ministries of Education
http://www2.unescobkk.org/elib/publications/aids_toolkits/index.htm

- UNAIDS Inter-Agency Task Team on Education – Quality Education and HIV and AIDS.
<http://unesdoc.unesco.org/images/0014/001461/146115e.pdf>



International Commitments

ASEAN's Efforts in Combating HIV and AIDS
www.aseansec.org/zip/ASEAN_combat_aids.pdf

Millennium Development Goals
www.undp.org

UNAIDS Progress Report on the Declaration of Commitment on HIV and AIDS
http://data.unaids.org/pub/Report/2006/20060324_SGReport_GA_A60737_en.pdf

Education for All Initiative - UNESCO
<http://www.unesco.org/education/efa/>

Convention on the Rights of the Child
<http://www.hrweb.org/legal/child.html>

The International Bill of Human Rights
<http://www.ohchr.org/english/about/publications/docs/fs2.htm>

Gender

Women, Gender and HIV and AIDS in East and Southeast Asia
www.unifem-eseasia.org/resources/others/genaids/genaid2a.htm

International Community of Women Living with HIV and AIDS: Positive Women's Survival Kit
www.icw.org/files/Survival%20Kit.pdf

World Health Organization: Gender and HIV and AIDS
http://www.who.int/gender/hiv_aids/en/

MSM

Mapping the AIDS Pandemic: Male-Male Sex and HIV and AIDS in Asia
www.mapnetwork.org/docs/MAP_%20Book_04July05_en.pdf

Family Health International
<http://www.fhi.org/en/HIVAIDS/pub/fact/intervenmsm.htm>

HIV Prevention and Young Men Who Have Sex with Men
<http://www.advocatesforyouth.org/publications/iag/ymsm.htm>

UNAIDS Policy Brief on MSM
http://data.unaids.org/Publications/IRC-pub07/jc1269-policybrief-msm_en.pdf?preview=true

3



IDU

Mapping the AIDS Pandemic: Drug Injection and HIV and AIDS in Asia

<http://www.mapnetwork.org/docs/>

Keeping in Touch – the Kit: Working with Alcohol and Other Drug Use. A Resource for Primary and Secondary Schools from the Australian Government.

<http://www.dest.gov.au/NR/rdonlyres/A1C906F9-1894-46C0-A741-3D7A0741F9C8/12473/>

[KeepingInTouch_TheKit.pdf](#)

Family Health International

<http://www.fhi.org/en/HIVAIDS/pub/fact/reducingidus.htm>

Orphans and Vulnerable Children

East-West Centre: The HIV and AIDS Epidemic in Thailand: Addressing the impact on children

<http://www2.eastwestcenter.org/pop/misc/p&p-35.pdf>

AsiaAfrica: Article on Thai young people living with HIV and stigma

<http://www.aidsasiafrica.net/features/thailand7.html>

UNICEF United for Children, United Against AIDS

<http://www.unicef.org/uniteforchildren/index.html>

Family Health International

<http://www.fhi.org/en/HIVAIDS/pub/fact/carorphans.htm>

4

Young People and HIV

Responding to the Prevention Needs of Adolescents and Young People in Asia: Towards cost-effective policies and programmes

http://www2.unescobkk.org/hivaids/fulltextdb/aspUploadFiles/Aids%20Commission%20in%20Asia_06September_07.pdf



Glossary



Samoa © UNESCO/L. Berdejo

Cover photo: Saint Mary's Primary School in Apia.

Glossary

In learning about HIV and AIDS, you may come across the following terms and acronyms. This list is not exhaustive, which means that you may not find all the words and acronyms for which you look. Most of these terms and definitions are drawn from the “UNESCO Guidelines on Language and Content in HIV- and AIDS-Related Materials”.¹

Advocacy – influencing outcomes, including public policy and resource allocation decisions within political, economic, and social systems and institutions - that directly affect people’s lives

Affected by HIV and AIDS – HIV and AIDS have an impact on the lives of those who are not necessarily infected themselves, but who have friends or family members who are HIV-positive. They may have to deal with similar negative consequences, for example, stigma and discrimination, exclusion from social services, etc.

AIDS (Acquired Immunodeficiency Syndrome) – AIDS is a range of conditions – a syndrome – that occurs when a person’s immune system is seriously weakened by HIV infection. Someone who has HIV infection has antibodies to the virus, but may not have developed any of the illnesses that constitute AIDS.

Antibodies – proteins that the body makes to attack foreign organisms and toxins (often called antigens) that circulate in the blood. Antibodies are usually effective in removing antigens from the body. Following infection by some organisms such as HIV, however, the antibodies do not get rid of the antigen. They only mark its presence. When found in the blood, these ‘marker’ antibodies indicate that HIV infection has occurred.

ART (Antiretroviral Therapy) – a treatment that uses antiretroviral medicines to suppress viral replication and improve symptoms. Effective antiretroviral therapy requires the simultaneous use of three or four antiretroviral medicines, otherwise known as highly active antiretroviral therapy.

ARV (Antiretroviral drugs or medicines) – medication used to fight infection by retroviruses, such as HIV infection. These medicines reduce a person’s viral load, thus helping to maintain the health of the patient. However, antiretroviral drugs cannot eradicate HIV entirely from the body. Antiretroviral drugs work by suppressing the activity or replication of retroviruses such as HIV.

Bacteria – microbes composed of single cells that reproduce by division. Bacteria are responsible for a large number of diseases. Bacteria can live independently, in contrast to viruses, which can only survive within the living cells that they infect.

Bisexual – a person who is sexually attracted to both males and females

1. UNESCO Guidelines on Language and Content in HIV- and AIDS- Related Materials.
<http://unesdoc.unesco.org/images/0014/001447/144725e.pdf>



CBO – community-based organization

Cell – autonomous self-replicating units; all living organisms are composed of one or more cells

Child – any human being under the age of 18, according to the Convention on the Rights of the Child

Clinical trial – a study that tries to improve current treatment or find new treatments for diseases. Drugs are tested on people, under strictly controlled conditions.

Concentrated epidemic – when less than 1% of the general population, but more than 5% of any particular group, is infected

Condom – a sheath unrolled over the erect penis. Male condoms made from latex or polyurethane prevent conception and transmission of HIV and other STIs. Female condoms are available, as well. They are a pouch made of polyurethane inserted into the vagina before intercourse and held in place by a loose inner ring and fixed outer ring. The female condom prevents conception and provides protection from STIs. Unlike the male condom, it does not depend on the man's erection.

Diagnosis – the determination of the existence of a disease or condition

Discrimination – when someone or a group of people does not allow a person the same opportunities and human rights as other people because that person has certain characteristics, conditions, behaviours or beliefs

Empowerment – enabling people to take more control over their daily lives. The term 'empowerment' is often used in connection with marginalised groups, such as women, men who have sex with men, or sex workers.

2

Epidemic – the rapid spread of a disease through a demographic segment of the human population, such as everyone in a given geographic area (e.g., a military base or similar population unit) or everyone of a certain age or sex (such as the children or women of a certain region). Epidemic diseases can be spread from person to person or from a contaminated source such as food or water.

Epidemiology – the branch of medical science that deals with the study of incidence, distribution and control of a disease in a population

Gay and lesbian – common terms for people who are sexually attracted to others of the same sex; 'gay' can be applied to both males and females, while the term 'lesbian' is reserved for females

Generalized epidemic – when more than 1% of the total population is infected

Heterosexual – a person who is sexually attracted to persons of the opposite sex

High-risk behaviour – a term used to describe activities that increase a person's risk of transmitting or becoming infected with HIV. Examples of high-risk behaviours include: unprotected vaginal or anal intercourse (without a condom) or using contaminated injection needles or syringes. These are often also referred to as unsafe activities.

HIV (Human Immunodeficiency Virus) – the retrovirus that causes AIDS in humans

Homosexual – a person who is sexually attracted to persons of the same sex

Immune system – the body's defence system that prevents and fights off infections

Incubation period – the time interval between HIV infection and the onset of AIDS-defining illnesses



IDU – injecting drug use

Life skills - refers to a large group of psycho-social and interpersonal skills which can help people make informed decisions, communicate effectively, and develop coping and self-management skills that may help them lead a healthy and productive life

Maternal antibodies – antibodies that have been passively acquired from the mother in utero; because maternal antibodies to HIV continue to circulate in the infant's blood up to the age of 15-18 months, it is difficult to determine whether the infant is infected

Microorganism - any organism that can only be seen with a microscope; protozoans, bacteria, fungi, and viruses are examples of microorganisms

MSM – men who have sex with men

Monogamy – having sexual relations with only one partner

Opportunistic infection – infections caused by organisms that do not normally cause disease in people whose immune systems are intact. Some of the most common opportunistic infections indicating that someone has AIDS are: PCP (pneumocystic carinii pneumonia), oesophageal candidiasis and toxoplasmosis.

Orphans – children whose parents have died. With respect to AIDS, orphans are usually defined as children under the age of fifteen who have lost one or both parents due to AIDS

Pandemic - a disease prevalent throughout an entire country, continent or the whole world

Pathogen – an agent such as a virus or bacteria that causes disease

Peer education – a teaching-learning methodology that can develop, strengthen, and empower young people to take an active role in influencing policies and programmes

Plasma – the fluid portion of the blood

PLHIV – people living with HIV

PTCT – parent-to-child transmission (of HIV)

PPTCT – prevention of parent-to-child transmission

Prevalence rate – a measure of the proportion of people in a population affected with a particular disease at a given time. The terms prevalence and incidence should not be confused. Incidence only applies to the number of new cases, while the term prevalence applies to all cases, old and new.

Rape – sexual intercourse with an individual without his or her consent

Safer sex – sexual activities that are not likely to transmit HIV. Safer sex involves sexual expressions in which partners make sure that blood, semen, vaginal mucus and menstrual blood from one person do not come into contact with the other person's bloodstream or mucous membranes (vulva, vagina, rectum, mouth and/or nose). This can be prevented by the use of properly used male or female condoms.

Serological testing – testing of a sample of blood serum

Seronegative – testing negative for HIV antibodies



Seropositive – testing positive for HIV antibodies

Sexual assault – any undesired physical contact of a sexual nature perpetrated against another person. While associated with rape, sexual assault is much broader and the specifics may vary according to social, political or legal definition.²

Sex worker - individual who has sex with other persons with a conscious motive of acquiring money, goods, or favours in order to make a full-time or part-time living for her/himself or for others

Sexually transmitted infections (STIs) – infections that can be transmitted through sexual intercourse or genital contact. HIV is essentially a sexually transmitted infection

Stigma – social disapproval or non-acceptance of a person that happens when members of a community believe that certain personal characteristics, conditions, behaviours or beliefs are undesirable, inferior or against common customs or practices

Symptom – sign of change in the body that indicates disease

Vaccine - a substance that contains antigenic components, either weakened, dead, or synthetic, from an infectious organism that is used to produce active immunity against that organism

VCCT – voluntary confidential counselling and testing

Viral load – the quantity of the virus in the bloodstream; the viral load of HIV is measured by sensitive tests that are unavailable in many parts of the world

Virus – infectious agent responsible for numerous diseases in all living beings. They are extremely small particles and, in contrast to bacteria, can only survive and multiply within a living cell at the expense of that cell.

Vulnerable children – children who (because of their circumstances or situation) are at risk of being infected with HIV, or children who are affected by the epidemic because a parent, sibling or caregiver is infected with the virus. Children may be vulnerable because of their involvement with drugs or sexual behaviours. They may be vulnerable if they have no caregiver. Street children have no caregivers, so are vulnerable.

WSW – women who have sex with women

Young people – people between the ages of 15 to 24

2. www.wikipedia.org

